92-372

No. _____

Supreme Court, U.S.
FILED
AUG 31 1992
OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

October Term, 1992

MARY TATARANOWICZ, *et al.*,
Petitioners,

vs.

LOUIS W. SULLIVAN, M.D.,
Secretary, Department of Health and Human Services,
Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

Whether the United States Court of Appeals for the District of Columbia Circuit erred when it ignored established rules of statutory construction and upheld the rewriting of an unambiguous statutory provision by the Secretary of Health and Human Services to deny Petitioners Medicare coverage under the transitional benefits provisions of § 101(b)(1) of the Medicare Catastrophic Coverage Repeal Act of 1989?

LIST OF PARTIES

The named parties to the proceeding in the United States Court of Appeals for the District of Columbia Circuit were Petitioners, Mary Tataranowicz, Corrine Dickenson, Jewel Wilson, Lucille Haggard, Winifred Stechman, Evelyn Tuttle, Thelma Hadley, Grace Easley, Mary Kirwin, Margaret Heffner, William Gettig, Beatrice Clark, Roxa Parker, and the Respondent, Louis W. Sullivan, M.D., in his official capacity as Secretary of the United States Department of Health and Human Services.

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Secretary, Department of Health and Human Services,
Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

The Petitioners respectfully pray that a Writ of Certiorari issue to review the judgment of the United States Court of Appeals for the District of Columbia Circuit in this case.

OPINIONS OF THE COURTS BELOW

The Panel opinion of the United States Court of Appeals for the District of Columbia Circuit, dated March 13, 1992, upheld the Secretary of Health and Human Services' (''Secretary's'') construction of § 101(b)(1)(C) of the Medicare Catastrophic Coverage Repeal Act of 1989 (''Repeal Act''), Pub. L. No. 101-234, 103 Stat. 1979, and reversed the Memorandum Opinion of the United States District Court for the District of Columbia Circuit. The Panel's opinion is reported at

959 F.2d 268 and reproduced in the Appendix at A-1. The Memorandum Opinion of the United States District Court for the District of Columbia, dated December 21, 1990, denied the Defendant's Motion to Dismiss, granted the Plaintiffs' motion for class certification, and granted the Plaintiffs' Motion for Summary Judgment. The District Court's opinion is reported at 753 F. Supp. 978 and is reproduced in the Appendix at A-31.

JURISDICTION

The decision of the United States Court of Appeals for the District of Columbia Circuit was issued on March 13, 1992. The Petitioners filed a timely Petition for Rehearing and Suggestion for Rehearing *En Banc* on April 27, 1992. The Orders denying the Petition for Rehearing and Suggestion for Rehearing *En Banc* were entered on June 1, 1992 and are reprinted in the Appendix at A-56. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1).

STATUTE INVOLVED

Pursuant to Sup. Ct. R. 14.1(f), the text of § 101 of the Repeal Act (42 U.S.C. § 1395e note) is reproduced in the Appendix at A-58.

STATEMENT OF THE CASE

I. Nature Of The Case

The precise question to be resolved in this case is whether the United States Court of Appeals for the District of Columbia Circuit erred when it ignored settled rules of statutory construction, established and applied by this Court and by various United States Courts of Appeals, and deferred to

the Secretary's rewriting of a plainly worded, unambiguous statutory provision containing clearly defined terms. The clause at issue, § 101(b)(1) of the Repeal Act, is a provision that granted transitional Medicare coverage for individuals receiving "extended care services" in "skilled nursing facilities" ("SNFs") at the end of 1989 and the beginning of 1990. The Secretary issued manual instructions which narrowly construed this transitional provision to exclude from Medicare coverage individuals who otherwise have qualified for benefits under the plain language of the statute. As a result of the Secretary's narrow construction, ratified by the Court of Appeals, an estimated $460 million in Medicare benefits have not been paid for the care of eligible beneficiaries. *See* Declaration of Solomon Mussey, Director of the Office of Medicare Cost Estimates (Appendix at A-61). Because this has resulted in the deprivation of Medicare benefits to thousands of elderly patients, responsibility for the costs of their care has been shifted from the Medicare program to other payors (*e.g.*, the patients themselves, state Medicaid programs, and private insurers).

II. Background

A. Statutory Framework

The Medicare program, which subsidizes the medical care of the elderly and disabled, was enacted by Congress in 1965 as Title XVIII of the Social Security Act. *See* Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286. *See also* 42 U.S.C. § 1395 *et seq.* Under the Medicare program, the federal government reimburses health care providers for expenses incurred in providing certain medical services to Medicare beneficiaries. The Medicare program is divided into two parts. Part A provides insurance for hospital and related post-hospital services. *See* 42 U.S.C. § 1395c *et seq.* Part B provides insurance for supplemental medical services, such

as services by a physician. *See* 42 U.S.C. § 1395j *et seq.*

This case deals with Medicare Part A benefits for post-hospital extended care services in an SNF. Prior to January 1, 1989, Medicare provided Part A coverage to reimburse post-hospital "extended care services" in an SNF for up to 100 days during each "spell of illness."[1]

From January 1, 1989 through December 31, 1989, Medicare coverage of extended care services received in an SNF was governed by the Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, 102 Stat. 683 (1988) ("MCCA"). The MCCA expanded the pre-MCCA Medicare coverage by providing Medicare Part A benefits for "extended care services for up to 150 days during any calendar year." *See* Pub. L. No. 100-360, § 101(2). Thus, the MCCA increased SNF coverage from 100 days in a benefit period to 150 days per calendar year and eliminated the pre-MCCA requirements that a beneficiary be hospitalized for at least three days before a timely transfer to an SNF. The MCCA also eliminated the requirements pertaining to spell of illness.

The Repeal Act, enacted on December 13, 1989, generally restored the requirements for Medicare coverage of extended care services that were in effect prior to the adoption of the MCCA. Namely, Medicare Part A will now reimburse only

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[1]Under 42 U.S.C. § 1395x(a), the term "spell of illness" is defined as a consecutive period beginning when the beneficiary entered a hospital or received extended care services and ending when the beneficiary has not been an inpatient of a hospital or SNF for 60 consecutive days. The statute defines "extended care services" as services furnished by a skilled nursing facility to an inpatient. 42 U.S.C. § 1395x(h). A "skilled nursing facility" is "an institution (or a distinct part of an institution) which is primarily engaged in providing to residents . . . skilled nursing care and related services," and which satisfies certain quality of care requirements. 42 U.S.C. § 1395i-3(a). Thus, the terms "extended care services" and "skilled nursing facility services" are synonymous and unambiguous.

post-hospital "extended care services" in an SNF for up to 100 days during each "spell of illness." Pub. L. No. 101-234, § 101(a)(1). Eligibility for the 100 days of SNF Medicare coverage available under the restored post-hospital requirement mandates that the beneficiary be transferred to an SNF (or to an approved swing-bed portion of a hospital) from a hospital in which the beneficiary was a patient for no less than three consecutive calendar days and that such transfer generally be made within a period of thirty days after discharge from the hospital. *See* 42 U.S.C. §§ 1395x(h) and (i).

To effect the transition from the requirements for Medicare Part A eligibility under MCCA to the requirements for Medicare coverage under the Repeal Act, Congress specifically prescribed transition rules in § 101(b) of the Repeal Act. This section provides, in pertinent part:

> In applying sections 1812 and 1813 of the Social Security Act [42 U.S.C. §§ 1395d and 1395e], as restored by subsection (a)(1) [of the Repeal Act], with respect to . . . extended care services provided on or after January 1, 1990 —
>
> (A) no day before January 1, 1990, shall be counted in determining the beginning (or period) of a spell of illness;
>
> (B) with respect to the limitation on such services provided in a spell of illness, days of such services before January 1, 1990, shall not be counted . . . ;
>
> (C) *the limitation of coverage of extended care services to post-hospital extended care services shall not apply to an individual receiving such services from a skilled nursing facility during a continuous period beginning before (and including) January 1, 1990,* until the end of the period of 30 consecutive days in which the individual is not provided inpatient hospital or extended care services . . . .

See Pub. L. No. 101-234, § 101(b)(1), 42 U.S.C. 1395e note (emphasis added). Accordingly, under the plain language of § 101(b)(1), SNF residents who received "extended care services" on and after January 1, 1990, are: (a) considered to have begun a new benefit period on January 1, 1990, irrespective of whether they exhausted their Medicare-covered SNF benefit days in 1989, and (b) exempt from the reinstated post-hospital requirement, if they *received extended care services from an SNF* continuously during a period including December 31, 1989 and January 1, 1990.

B. The Secretary's Policy

The Secretary went beyond the plain language of the Repeal Act and restricted the availability of transitional Medicare SNF benefits by imposing an additional requirement for eligibility under the post-hospital requirement waiver in § 101(b)(1)(C):[2]

> A beneficiary whose stay in a SNF (or at the SNF level of care in a swing-bed hospital) continues from 1989 to 1990 is initially exempt from the post-hospital requirement that is reinstated in 1990 . . . if all other requirements for *Medicare* payment for extended care services are met for a continuous period that includes at least 12/31/89 and 1/1/90 . . . . If Medicare payment cannot be made for extended care services furnished on both December 31, 1989 and January 1, 1990, this transition exemption does not apply.

Claims Manual, at IM 3623 (emphasis added).

Under this construction, in order for an SNF resident to be eligible for Medicare coverage for SNF services furnished

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[2]The policy of the Secretary is set forth in the Medicare Intermediary Manual ("Claims Manual"), Part 3, Claims Process, HCFA-Pub. 13-3, IM 3623 (Transmittal IM-90-1) (Feb. 1990).

on or after January 1, 1990, without satisfying the reinstated post-hospital requirement, the individual must not only have received extended care services from an SNF, as § 101(b)(1)(C) expressly provides, but, in addition, the individual must also have qualified for *Medicare* payment for those services on both December 31, 1989 and January 1, 1990 — a condition not imposed by the Repeal Act.

The Secretary's construction effectively means that SNF residents who were not transferred from a hospital and who exhausted their Medicare SNF benefits prior to January 1, 1990, would not qualify for coverage under the post-hospital exemption even though they would otherwise have been eligible for benefits in 1990 under the MCCA. Consequently, such residents were denied up to 100 days of Medicare benefits for extended care services received from an SNF in 1990.[3]

C. Proceedings In The District Court

The Petitioners filed suit in the District Court on April 20, 1990, on their own behalf and on behalf of others similarly

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[3]The Panel majority's opinion provides a number of examples to illustrate the effects of the Secretary's interpretation of § 101(b) of the Repeal Act. 959 F.2d at 270-71. Most notably, Example B describes a patient who is in an SNF on December 31, 1989; this patient has exhausted the 150 days of Medicare coverage provided in 1989 under the MCCA but has previously satisfied the restored post-hospitalization requirement. Under the Secretary's view, as upheld by the Panel majority, this patient would qualify for transitional coverage due to the fact that the patient satisfied the post-hospitalization requirement. In Example C, a patient is in an SNF on December 31, 1989 and has previously exhausted his or her 150 days of Medicare coverage under the MCCA but has not previously satisfied the post-hospitalization requirement. Under the Secretary's view, as confirmed by the Panel majority, this person would not qualify for transitional coverage under the Repeal Act despite remaining in the SNF on and after January 1, 1990.

situated. The District Court had subject matter jurisdiction over this case pursuant to 28 U.S.C. §§ 1331 and 1361, and 42 U.S.C. §§ 1395ff, 1343, 405(b) and 405(g).

The Petitioners sought review of the Secretary's construction of the Repeal Act. The named Petitioners were receiving extended care services in their respective SNFs when the Repeal Act took effect at midnight on December 31, 1989. At that time, the Petitioners had exhausted the 150 days of annual Medicare coverage alloted to them under the MCCA and, pursuant to the Secretary's policy, did not qualify for the transition benefits under § 101(b), despite having received extended care services in their SNFs on December 31, 1989 and January 1, 1990.

The District Court (Sporkin, J.) certified a nationwide class and ruled for the class on the merits, finding that the Secretary's interpretation of § 101(b) was contrary to the plain and unambiguous meaning of the statutory text at issue. *See* 753 F. Supp. at 982, 984-85. As a result, the District Court declared the Secretary's interpretation of the Repeal Act's transition provisions to be invalid. The Secretary was ordered to apply the correct interpretation of the transition provisions to benefit claims brought by individuals who were receiving extended care services in an SNF for a continuous period, including December 31, 1989 and January 1, 1990, regardless of whether the Medicare program was reimbursing SNFs for their care on those dates. *Id.* Under the District Court's Order, individuals who were receiving extended care services in an SNF on December 31, 1989 and January 1, 1990 would be eligible for a waiver of the post-hospital requirement, and thus qualify for up to 100 days of Medicare coverage in 1990, even if the services received on those days were not reimbursed by Medicare.[4]

[4]The Secretary filed a Motion For A Stay Pending Appeal with the District Court on February 1, 1991. The Motion was denied on February 26, 1991. A copy of the District Court's Memorandum Opinion and Order denying the Motion is reproduced in the Appendix at A-51.

D. Decision Of The Court Of Appeals

The Secretary filed a notice of appeal on February 1, 1991.[5] Oral argument before a three-judge Panel of the United States Court of Appeals for the District of Columbia Circuit was held on September 13, 1991. On March 13, 1992, the Panel issued a 2-1 decision.[6] The Panel majority upheld the construction and application of a § 101(b)(1)(C) of the Repeal Act by the Secretary and reversed the decision of the District Court on the merits.[7]

In reaching its decision, the Panel majority went beyond the plain language of the statute to conclude that the statutory provision was unclear and, consequently, the Secretary's interpretation was entitled to deference. The Panel majority resorted to inconclusive "legislative history", a vague caption heading, its own questionable views on the conventional purposes of grandfathering, and unilluminating Congressional Budget Office ("CBO") cost estimates in concluding that the intent of Congress was not clearly expressed in the statute and, therefore, the Secretary's interpretation was reasonable. A timely Petition for Rehearing and Suggestion for Rehearing *en banc* was filed by the Petitioners on April 27, 1992 and denied on June 1, 1992.

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[5]On April 26, 1991, the Secretary filed a Motion for a Stay Pending Appeal and to Expedite Briefing Schedule and Oral Argument. On May 22, 1991, the Court of Appeals issued Orders granting the Secretary's Motion. Copies of the Orders are reproduced in the Appendix at A-53.

[6]Judge Williams authored the majority opinion and was joined by Judge Lourie (United States Court of Appeals for the Federal Circuit), sitting by designation. *See* 28 U.S.C. § 291(a). Judge Buckley dissented.

[7]The Panel majority also limited the size of the class which had been certified by the District Court. However, the Petitioners do not seek certiorari with regard to this aspect of the Panel majority's decision.

REASONS FOR ALLOWANCE OF THE WRIT

Simply put, the Court of Appeals in this case has decided a question of statutory construction involving a federal statute in a way that patently conflicts with applicable decisions of this Court and various United States Courts of Appeals. Moreover, although the Secretary's interpretation involves a transitional provision in effect during a limited period of time, that interpretation affects thousands of elderly individuals and implicates hundreds of millions of dollars. Consequently, this Petition for a Writ of Certiorari should be granted. *See* Sup. Ct. R. 10.1(c).

In construing a statute, a court must first inquire whether Congress "has directly spoken to the precise question at issue." *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842 (1984). If Congress has so spoken, "that is the end of the matter," except in "rare cases [in which] the literal application of a statute will produce a result *demonstrably* at odds with the intentions of its drafters." *Id.; United States v. Ron Pair Enterprises*, 489 U.S. 235, 241-42 (1989), *quoting Caminetti v. United States*, 242 U.S. 470, 485 (1917) and *Griffin v. Oceanic Contractors, Inc.*, 458 U.S. 564, 571 (1982) (emphasis added). Only if Congress has not spoken directly to the issue is it appropriate for courts to determine the permissibility of an agency's statutory interpretation by examining its reasonableness. *Chevron*, 467 U.S. at 843-44.

In this case, the unambiguous, statutorily-defined language used by Congress in § 101(b)(1)(C) of the Repeal Act is indicative of congressional intent. Correspondingly, the absence of any clear and demonstrable evidence of congressional intent supporting the Secretary's construction of § 101(b)(1)(C) of the Repeal Act made it highly improper for the Court of Appeals to ignore the plain statutory language and to defer to the Secretary's interpretation.

I. The Court Of Appeals Incorrectly Concluded That Congress Had Not Spoken Directly To The Issue Of Medicare Transitional Coverage For Extended Care Services In § 101(b)(1)(C) Of The Repeal Act.

A. The Statutory Language Is Clear On Its Face

It is hard to imagine a clearer, more precise statutory provision than the one at issue. On its face, § 101(b)(1)(C) of the Repeal Act establishes one condition in order for an individual to be exempted from the post-hospital requirement and eligible for Medicare transitional benefits in 1990. Namely, the individual must have been receiving extended care services from an SNF during a continuous period beginning before (and including) January 1, 1990. The statutory language does *not* impose an additional requirement that those services be reimbursed by Medicare. In fact, in its opinion, the Panel majority conceded that the statutory language is facially clear and that there simply is no further express qualification as to the extended care services being reimbursed by Medicare. *See* 959 F.2d at 276.

The effect of the language employed by Congress is also clear. If an SNF resident who would have qualified for MCCA benefits in 1990 was (a) "receiving extended care services," (b) from a "skilled nursing facility," (c) "for a continuous period beginning before (and including) January 1, 1990," that resident is eligible for 100 days of SNF Medicare coverage in 1990 without having to satisfy the restored post-hospitalization rule. The Secretary's imposition of the additional requirement that SNF residents actually receive Medicare coverage on December 31, 1989 and January 1, 1990 in order to qualify for the post-hospital waiver available under § 101(b)(1)(C) not only conflicts with the plain language of the transition provision, but effectively rewrites the provison.

The pertinent terms in the provision are specifically defined within the Social Security Act. The Secretary's interpretation is necessarily based upon the assumption that the term "extended care services," as used in § 101(b)(1)(C), means services received at a skilled level of care *that are reimbursed by Medicare.* Yet, the statutory definition of "extended care services" imposes no requirement of Medicare reimbursement. *See* 42 U.S.C. § 1395x(h) and n.1, *supra.* Thus, under this definition, one can receive extended care services that are reimbursed by sources other than Medicare (*e.g.*, private insurers, Medicaid). In fact, the Secretary's own regulations specify the particular instances when "extended care services" are entitled to Medicare reimbursement. *See* 42 C.F.R. § 409.30 *et seq.* Consequently, there is no justification found either within the statutory provision at issue or within the statutory definition of "extended care services" which suggests that the use of the term "extended care services" in § 101(b)(1)(C) is unclear and may refer only to those "extended care services" which were reimbursed by Medicare.

B. The Intent Of Congress Is Demonstrated By Plain, Unambiguous Statutory Language

By effectively ignoring the direct statutory language and by imposing an additional requirement for transitional Medicare coverage under § 101(b)(1)(C) of the Repeal Act that is not found or implied anywhere in the statute, the Panel majority ruling is at odds with numerous decisions of this Court and other United States Courts of Appeals.

In determining legislative intent, a court must "begin with the language employed by Congress [in the statute] and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose." *Morales v. Trans World Airlines, Inc.*, ____ U.S. ____, 112 S.Ct. 2031, 2036 (1992).

In all cases involving statutory construction, the "starting point [in determining congressional intent] must be the language employed by Congress." *Reiter v. Sonotone Corp.*, 442 U.S. 330, 337 (1979). "[C]ourts must presume that a legislature says in a statute what it means and means in a statute what it says there. When the words of a statute are unambiguous, then, this first canon is also the last: 'judicial inquiry is complete'." *Connecticut National Bank v. Germain*, ____ U.S. ____, 112 S.Ct. 1146, 1149 (1992) (citations omitted).

As previously demonstrated, the statutory phrase at issue in this case contains clearly expressed terms, the meaning of which are explicitly defined elsewhere in the Social Security Act. In interpreting statutory terms that are either defined or have established meanings, courts should assume that "the legislative purpose is expressed by the ordinary meaning of the words used." *Richards v. United States*, 369 U.S. 1, 9 (1962). Thus,

> *[w]here [a statutory provision] . . . contains a phrase that is unambiguous — that has a clearly accepted meaning in both legislative and judicial practice — we do not permit it to be expanded or contracted. . . .*

West Virginia University Hospitals, Inc. v. Casey, ____ U.S. ____, 111 S.Ct. 1138, 1146-47 (1991) (emphasis added). In this regard, unless otherwise noted, a word or phrase with a defined or accepted meaning is presumed to have the same meaning within the same statute. *See Moore v. Raine*, 907 F.2d 1476 (4th Cir. 1990).

In *Molzof v. United States*, ____ U.S. ____, 112 S.Ct. 711 (1992), this Court explained that:

> where Congress borrows terms of art in which are accumulated the legal tradition and meaning of centuries of practice, it presumably knows and adopts the cluster of ideas that were attached to each

> borrowed word in the body of learning from which it was taken and the meaning its use will convey to the judicial mind unless otherwise instructed. In such case, absence of contrary direction may be taken as satisfaction with widely accepted definitions, not as a departure from them.

Id. at 716 (citations omitted).

In *Ardestani v. INS*, ____ U.S. ____, 112 S.Ct. 515, 520 (1991), the Court reiterated its commitment to interpreting statutes by applying the ordinary or established meaning of the language employed. In holding that the Equal Access to Justice Act did not apply to administrative deportation proceedings, the Court stated that:

> [t]he 'strong presumption' that the plain language of the statute expresses congressional intent is rebutted *only* in 'rare and exceptional circumstances,' when a contrary legislative intent is *clearly* expressed. In this case, the legislative history cannot overcome the strong presumption *'that the legislative purpose is expressed by the ordinary meaning of the words used.'*

Id. at 519 (emphasis added) (citations omitted).

It was manifestly improper for the Court of Appeals to sanction the Secretary's limitation of § 101(b)(1)(C) by effectively redefining what is meant by the phrase "extended care services" received from a "skilled nursing facility." The pertinent terms found in § 101(b)(1)(C) are specifically defined within the Social Security Act. *See* 42 U.S.C. §§ 1395i-3(a) and 1395x(h).[8] Thus, the transition provision's reference to "extended care services" received from a "skilled nursing facility" leaves no doubt as to what is meant. These definitions refer to levels and types

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[8]*See* n.1, *supra.*

of care not to the payment source for that care. Neither the definitions for these terms nor the transition provision itself imposes any requirement that extended care services must be reimbursed by Medicare in order for an individual to qualify for transitional Medicare coverage under the Repeal Act.

Where the plain language of a statute has a term which is clearly defined or has an accepted meaning, a court "must give effect to this plain language unless there is good reason to believe Congress intended the language to have some more *restrictive* meaning." *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 97 (1983) (emphasis added). As demonstrated below, there was no "good reason" that would justify adopting an additional restriction limiting the application of a § 101(b)(1)(C).

II. The Court Of Appeals Improperly Deferred To The Secretary's Interpretation Of § 101(b)(1)(C) Of The Repeal Act Despite The Lack Of Clear And Demonstrable Evidence That Application Of The Express Terms Of The Statute Was Contrary To The Intent Of The Drafters.

This is not a case in which "the literal interpretation of a statute will produce a result demonstrably at odds with the intention of its drafters." *See Ron Pair*, 489 U.S. at 242; *Griffin*, 458 U.S. at 571. These "rare" cases:

> must involve, at a minimum, some *clear* indication of congressional intent, either in the legislative history or in the structure of the relevant statute, that informs the specific language in question; any attempt less grounded in the words of the legislature itself to further what a court perceives to be Congress' general goal in enacting a statute is simply too susceptible to error to be tolerated within our scheme of separated powers.

Consolidated Rail Corp. v. United States, 896 F.2d 574, 578 (1990) (emphasis added). *Accord Consumer Product Safety Commission v. GTE Sylvania, Inc.*, 447 U.S. 102, 108 (1980) (to dislodge the plain meaning of a statutory provision, there must be "*obvious*" evidence of a "clearly expressed", contrary congressional intent) (emphasis added).[9]

Neither the Secretary nor the Panel majority has suggested that application of the plain meaning of the statute in this case would produce a result which is clearly at odds with the intentions of the Congress.[10] Moreover, neither the Secretary nor the Panel majority has pointed to any demonstrable and clear evidence which could override the plain statutory language. Instead, the Secretary's position, and the Panel majority's conclusions, are predicated upon a weak patchwork of justifications that do not withstand scrutiny: (1) dubious use of the legislative history of the Repeal Act, (2) puzzling references to a statutory subheading, (3) doubtful speculation about the conventional purposes of grandfathering, and (4) perplexing use of CBO cost estimates. As shown below, and as Judge Buckley explained in his dissent, ". . . the majority points

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[9]*Accord Estate of Cowart v. Nicklos Drilling Co.*, ____ U.S. ____, 112 S.Ct. 2589 (when a statute speaks clearly, a court's inquiry into the statute's meaning, absent the most *extraordinary* circumstance, is completed); *Ardestani*, 112 S.Ct. at 520 (plain statutory language rebutted only when *clear* expression of contrary legislative intent); *Demarest v. Manspeaker*, ____ U.S. ____, 111 S.Ct. 599, 604 (1991) ("[w]hen we find the terms of a statute unambiguous, judicial inquiry is complete except in *rare and exceptional circumstances*") *(emphasis added); American Tobacco Co. v. Patterson*, 456 U.S. 63, 68 (1981) (absent a *clearly expressed* legislative intention to the contrary, the statutory language must be regarded as conclusive).

[10]In his appellate brief submitted before the Court of Appeals, the Secretary has, in fact, explicitly admitted that the statute's plain language and the Petitioners' position are consistent with the legislative scheme. *See* Brief For The Appellant (filed June 26, 1991) at 15-16.

to no precedent in which the Supreme Court . . . has found clear statutory language ambiguous on such slender reeds as the ones on which it relies." *See* 959 F.2d at 281.

First, the Panel majority's resort to "legislative history" was questionable given the lack of ambiguity in the statute. *Barnhill v. Johnson*, ____ U.S. ____, 112 S.Ct. 1386, 1391 (1992). Beyond that, however, Congressional committee reports are not even cited by the Panel majority in its consideration of the legislative history. The sole legislative materials referenced by the Panel majority to sanction the Secretary's additional non-statutory restriction on transitional Medicare benefits are several oblique statements of individual congressmen. *See* 959 F.2d at 278-79. However, as this Court has noted in *West Virginia University Hospitals, Inc.*, "[w]here . . . [the statutory text] contains a phrase that is unambiguous . . . we do not permit it to be expanded or contracted by the statements of individual legislators . . . during the course of the enactment process." *See* 111 S.Ct. at 1147.

In this regard, "[w]hile a sponsor's statements may reveal *his* understandings and intentions, they hardly provide definitive insights into *Congress'* understanding of the meaning of a particular provision." *Overseas Education Association, Inc. v. FLRA*, 876 F.2d 960, 975 (D.C. Cir. 1987) (Buckley and Starr, JJ., concurring) (emphasis in original). "[E]ven if it is . . . a crystal clear Committee Report, one can never be sure that the legislators who voted for the text of the bill were aware of it." *United States v. R.L.C.*, ____ U.S. ____, 112 S.Ct. 1329, 1340 (1992) (Scalia, J., concurring). Thus, absent a definitive committee report, any remarks by individual legislators will provide evidence of congressional intent only where they are consistent with the statutory language and the other legislative history. *See Brock v. Pierce County*, 476 U.S. 253, 263 (1986). Such is not the case here. Indeed, as the

District Court pointed out after its own extensive review of these statements (753 F. Supp. at 982-83), far from supporting the Secretary's position, these statements tend to support the Petitioners' construction of the Repeal Act.

Second, the Panel majority's reliance (959 F.2d at 276-77) upon the statutory subheading to § 101(b), "Transition Provisions for Medicare Beneficiaries", was clearly improper. Statutory subheadings may not be used to contradict clear statutory language. According to this Court:

> [w]here . . . text is complicated and prolific, headings and titles can do no more than indicate the provisions in a most general manner . . . . As a result, matters in the text which deviate from those falling within the general pattern are frequently unreflected in the headings and titles. Factors of this type have led to the wise rule that *the title of a statute and the heading of a section cannot limit the plain meaning of a text.* For interpretative purposes, they are of use only when they shed light on some ambiguous word or phrase.

Brotherhood of Railroad Trainmen v. Baltimore & Ohio Railroad Co., 331 U.S. 519, 528-29 (1947) (emphasis added) (citations omitted).[11]

Third, the Panel majority's primary rationale for ignoring the plain language of the statute was its view that the Secretary's interpretation is consistent with the general purposes that are

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[11]Even if the caption could be considered, it is especially frail evidence that should do little to thwart the statute's plain meaning. After struggling to produce meaning to the subheading, the Panel majority itself acknowledged that, at best, the caption provided "*some* support" for the Secretary. *See* 959 F.2d at 276 (emphasis added). Judge Buckley found this effort both unpersuasive and irrelevant. *See* 959 F.2d at 281-82.

served by "grandfathering" provisions such as § 101(b)(1)(C). *See* 959 F.2d at 277. In this regard, this Court has warned against inquiries which exalt supposed legislative purpose over clear legislative language:

> [a]pplication of "broad purposes" of legislation at the expense of specific provisions ignores the complexity of the problems Congress is called upon to address and the dynamics of legislative action. . . . [T]he final language of the legislation may reflect hard-fought compromises. Invocation of the "plain purpose" of legislation at the expense of the terms of the statute itself takes no account of the processes of compromise and, in the end, prevents the effectuation of congressional intent.

Board of Governors of the Federal Reserve System v. Dimension Financial Corp., 474 U.S. 361, 373-74 (1986).

Nevertheless, even if consideration is to be given to the general purposes served by grandfather provisions such as § 101(b)(1)(C) of the Repeal Act, it seems apparent that the Panel majority simply allowed the statute to be rewritten to suit its perspectives of what Congress should have done. Unsurprisingly, however, this rewriting conflicts not only with the plain language of the statute but produces capricious results as well. In this vein, the Panel majority would lead one to conclude that, when Congress enacted the transition provisions, it created a broad and generous grandfathering as to the reinstatement of the spell of illness requirement,[12] but acted much more restrictively as to the reinstatement of the

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[12]Under §§ 101(b)(1)(A) and (B) of the Repeal Act, no day before January 1, 1990 would be counted in determining the commencement or the longevity of a spell of illness.

post-hospitalization requirement.[13] In fact, examples cited in the Panel majority's opinion, 959 F.2d at 270-71, highlight this inconsistency.[14]

Finally, the Panel majority's reliance upon CBO cost estimates as evidence suggesting a need to depart from the plain language of the statute was also unjustified. If legislative history is consulted, courts may, in some cases, consider CBO cost estimates a relevant portion of the legislative history. However, this is true where CBO cost estimates are incorporated by specific reference or reprinted in a House or Senate report on the bill. *See, e.g., Staub v. Office of Personnel Management,* 927 F.2d 571, 573 (Fed. Cir. 1991); *United States v. Simpson* 885 F.2d 36, 43 (3d Cir. 1989). There is no precedent suggesting that CBO cost estimates have any independent significance with respect to determining legislative intent simply by virtue

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[13]Under the Secretary's interpretation, individuals would qualify for transitional Medicare benefits only if they were hospitalized prior to their admissions to an SNF or if they were actually receiving Medicare SNF benefits on December 31, 1989 and January 1, 1990.

[14]*See, e.g.*, n.3, *supra.* Under the Secretary's interpretation and the Panel majority's reasoning, the patient in Example B would receive transitional Medicare coverage even if he had exhausted his benefits early in 1989 because he had previously been hospitalized and there is no transitional spell of illness requirement. The patient in Example C, who exhausts his benefits as late as December 31, 1989 and was not previously hospitalized, would receive no transitional benefits. Why the patient in Example B deserves greater consideration, or has more unsettled expectations, than the patient in Example C is difficult to comprehend, since neither would have received Medicare benefits in 1990 had the MCCA never been enacted. Why broader grandfathering should occur as to spell of illness than as to post-hospitalization is hard to appreciate. The Secretary and the Panel majority provide no explanations and, in fact, the statute's plain language leads to a more understandable result. Namely, Congress intended to provide transitional benefits, regardless of prior hospitalization and spell of illness requirements, to those who received Medicare benefits in SNFs in 1989, who remained into 1990, and who had every reason to believe — until the passage of the Repeal Act in late 1989 — that they would receive such benefits in 1990 under the MCCA.

of the fact that the CBO cost estimates exist. CBO cost estimates have absolutely no relevance in the absence of specific evidence linking them with congressional rationale for the legislative interpretation urged by the Secretary.[15]

No clear and demonstrable evidence has been advanced by the Panel majority to warrant the Secretary's departure from the unambiguous and precise language employed by Congress in drafting § 101(b)(1)(C) of the Repeal Act. Consequently, it was improper for the Panel majority to defer to the Secretary's rewriting of an unambiguous statutory provision.

CONCLUSION

For the foregoing reasons, this Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

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August 31, 1992

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[15]The Panel majority itself provides several reasons why these estimates are useless, calling them "perplexing," acknowledging their "vulnerabilities," and admitting that: "*[t]here is no clue what members of Congress might have received [them].*" *See* 959 F.2d at 279 (emphasis added).

APPENDIX

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

Argued September 13, 1991 Entered March 13, 1992

No. 91-5052

MARY TATARANOWICZ, et al.,
APPELLEES

v.

LOUIS W. SULLIVAN, M.D., IN HIS OFFICIAL CAPACITY AS SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES,
APPELLANT

Appeal from the United States District Court
for the District of Columbia

(Civil Action Number 90-00935)

Howard S. Scher, Attorney, Department of Justice, with whom *Stuart M. Gerson*, Assistant Attorney General, *Jay B. Stephens*, United States Attorney, and *Barbara Biddle*, Attorney, Department of Justice, were on the brief, for appellants.

Thomas C. Fox for appellees.

Bills of costs must be filed within 14 days after entry of judgment. The court looks with disfavor upon motions to file bills of costs out of time.

Before: BUCKLEY and WILLIAMS, *Circuit Judges*, and ALAN D. LOURIE,* *Circuit Judge*, U.S. Court of Appeals for the Federal Circuit.

Opinion for the Court filed by *Circuit Judge* WILLIAMS.

Dissenting opinion filed by *Circuit Judge* BUCKLEY.

WILLIAMS, *Circuit Judge*: In the Medicare Catastrophic Coverage Act of 1988 ("Catastrophic Coverage Act"), Pub. L. No. 100-360, 102 Stat. 683 (1988), Congress expanded Medicare coverage for services in qualified skilled nursing facilities ("SNFs"). The next year, reacting to protest by those on whom it had laid the expense, Congress reversed itself, enacting the Medicare Catastrophic Coverage Repeal Act of 1989 (the "Repeal Act" or "Act"), Pub. L. No. 101-234. The Repeal Act took effect December 31, 1989, largely restoring the *status quo ante*, but including a "transition provision" affording some continued protection to beneficiaries of the Catastrophic Coverage Act. See *id.* at 101(b)(1), 42 U.S.C.A. § 1395e note (West Supp. 1991). At issue here is how much. We find the transition provision ambiguous and the Secretary's construction of it reasonable. Accordingly, we reverse the district court's decision rejecting the Secretary's interpretation.

I.

Before the Catastrophic Coverage Act, eligible Medicare recipients were entitled to coverage of the costs of SNF services, subject to two restrictions. First, the coverage extended for only 100 days per "spell of illness"[1]; second,

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*Sitting by designation pursuant to Title 28 U.S.C. § 291(a).

[1]"Spell of illness" was defined as the period beginning the day on which coverage began and ending "with the close of the first period of 60 consecutive days" during which the patient is no longer "an inpatient of a skilled nursing facility." 42 U.S.C.A. § 1395x (West 1983). Thus, an individual who exhausted his or her 100 days of coverage could not leave an SNF for less than 60 days only to return again to begin a "new" spell of illness. But if a patient returned to a SNF after 60 days, he or she could resume coverage on a new 100 days.

the SNF services were covered only if they followed a hospital stay of at least three days. (Congress appears to have provided assistance for SNF costs on the theory that doing so would keep overall costs down by inducing patients to transfer from hospitals to less costly SNFs; it imposed the post-hospital stay requirement to limit the assistance to transfer cases. See S. Rep. No. 404, 89th Cong., 1st Sess., reprinted in 1965 U.S.C.C.A.N. 1943, 1971, 1987.) The Catastrophic Coverage Act removed the spell of illness limitation, substituting a simple limit of 150 days of SNF coverage per calendar year;[2] it completely deleted the post-hospital stay requirement. 42 U.S.C. § 1395d (1988). The Repeal Act returned to the prior regime by reinstating both limitations. 42 U.S.C.A. § 1395d(a) (West 1983 & 1991 Supp.).

To soften the blow, Congress included the following transition provision:

> **(b) Transition provisions for Medicare beneficiaries.**
>
> **— (1) Inpatient hospital services and post-hospital extended care services.**—In applying [42 U.S.C. §§ 1395d and 1395e], as restored by subsection (a)(1) [of the Repeal Act], with respect to inpatient hospital services and extended care services provided on or after January 1, 1990—
>
> > (A) no day before January 1, 1990, shall be counted in determining the beginning (or period) of a spell of illness;
> >
> > . . .
> >
> > (C) the limitation of coverage of extended care services to post-hospital extended care services shall not apply to an individual receiving such

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[2]Because the Catastrophic Care Act expanded coverage to 150 days *per calendar year* instead of 100 days *per spell of illness*, exactly what constituted a "spell of illness" became irrelevant. Patients might move in and out of SNFs repeatedly during a calendar year; regardless of the size of the interludes, their first 150 days were covered, and days after 150 were not.

> services from a skilled nursing facility during a continuous period beginning before (and including) January 1, 1990, until the end of the period of 30 consecutive days in which the individual is not provided inpatient hospital services or extended care services . . . .

Pub. L. No. 101-234, § 101(b)(1), 42 U.S.C. § 1395e note.

All hands appear to agree on how this affects the reinstituted spell-of-illness requirement. Everyone gets a fresh start in 1990, with 1989 bygones treated as completely bygone. Thus, a patient who was in a SNF at the end of 1989 and who satisfied the post-hospital stay requirement would start a spell of illness on January 1, 1990. This would be true regardless of whether the patient had exhausted the Catastrophic Coverage Act's 150-day allowable. Presumably the logic of this is that patients would have rested any decisions on the use of SNF services on the Catastrophic Coverage Act's 150-day rule being the sole limit and so should not be penalized in the next year for their use of that allowance.[3] Nor would it have made sense to require that the patient have been in a SNF on December 31, 1989; the purpose of subsection (A) is not to *continue* some kind of coverage but to relieve patients from adverse effects that events under the 1989 regime might otherwise have had on their allowables under the Repeal Act.

The parties diverge as to the post-hospital stay requirement. Plaintiffs, who have been or will be denied benefits under the Secretary's interpretation of § 101(b)(1)(C), read it as exempting all individuals who *received* SNF services on December 31, 1989 and January 1, 1990, regardless of whether the services on December 31, 1989 were covered by Medicare. The Secretary reads it as exempting from the post-hospital stay requirement only those patients whose stay on December 31 was *covered by Medicare*.

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[3]At least they would have done so until repeal, which occurred December 13, 1989.

These positions are most meaningful if we look at some specific examples:

(A) A patient is in a SNF on December 31, 1989 and January 1, 1990, having exhausted only 120 days of those allowable under the Catastrophic Coverage Act and having never had a hospital stay. The patient was eligible for coverage on December 31. Under the Secretary's view, the patient needs exemption from the post-hospital requirement and receives it because of his covered SNF stay on December 31. See Medicare Intermediary Claims Manual, Part 3 - Claims Process, Transmittal IM-90-1 ("Claims Manual"), Joint Appendix ("J.A.") 90, 94 (Example 1). Plaintiffs of course agree that this patient can start a covered spell of illness; he needs the exemption from the post-hospital requirement and receives it because of his presence in a SNF on December 31.

(B) A patient is in a SNF on December 31, 1989. He has previously exhausted the 150 days allowable in 1989 under the Catastrophic Coverage Act. He has, however, satisfied the post-hospital stay requirement. On both parties' views he will be covered (indeed, starts a spell of illness) on January 1, 1990. Under the Secretary's view, the key is that he has *satisfied* the post-hospital requirement. See Claims Manual, J.A. at 95 (Example 4). Under the plaintiffs', his presence in the SNF on December 31 assured coverage under the transition provision, regardless of his having also satisfied the post-hospital requirement.

(C) A patient has exhausted the Catastrophic Coverage Act's 150 days well before December 31, 1989 but remains in a SNF till the year's end and into 1990. He has never satisfied the post-hospital requirement. On plaintiffs' view, he is eligible to start coverage under a new spell of illness. As he was in the SNF on December 31, 1989 and continued there, he is exempt from the post-hospital requirement. On the Secretary's view, he is ineligible for coverage starting January 1, 1990. He has not satisfied the post-hospital requirement; since his stay on December 31,

1989 was not covered, he is not entitled to the exemption. See Claims Manual, J.A. at 94-95 (Example 2).

Mary Tataranowicz and thirteen other named plaintiffs brought a class action on behalf of themselves and all others who had been or would be denied benefits due to the Secretary's interpretation of the SNF transition provisions. The district court certified a class so defined and then held that the grandfather clause clearly and unambiguously exempted from the post-hospital requirement all who were SNF patients on December 31, 1989 and who continued in the SNF. Thus it found the Secretary's construction entitled to no deference. Accordingly, the court ordered the Secretary to exempt otherwise eligible SNF patients from the reinstated post-hospital requirement whether or not they had exhausted their 150 days of Medicare coverage for 1989.

The Secretary brings two challenges on appeal. First, he argues that no members of the certified class have satisfied the essential procedural prerequisites to suit — "presentment" and exhaustion. Second, he argues that the transition provision was ambiguous and his own construction reasonable. We find that some though not all of the plaintiff class have satisfied or been excused the requirements of presentment and exhaustion, but reverse on the merits.

II.

First we reject the Secretary's suggestion that we may leap over the jurisdictional or quasi-jurisdictional issues on the grounds that it is proper to do so when those issues are difficult, and the party raising them wins easily on the merits. See *Norton v. Mathews*, 427 U.S. 524 (1976); *Cross-Sound Ferry Services, Inc. v. Interstate Commerce Commission*, 934 F.2d 327, 332-34 (D.C. Cir. 1991). We need not consider whether the jurisdictional issues here are difficult enough, and the merits issues easy enough, to qualify under that doctrine. The Secretary calls our attention to no case in which the doctrine was invoked to

excuse the court's identifying the parties to the suit. But compare *Mathews v. Diaz*, 426 U.S. 67, 71-72 n.3 (1976) (in making final decision against constitutional attack on statute, the *Supreme Court*, whose decision will control all others, finds it unnecessary to find exact class boundaries). Here identifying the parties requires us to define the plaintiff class, which turns on the presentment and exhaustion issues. Without this determination, the collateral effect of the judgment would be completely obscure.

The Medicare Act, 42 U.S.C. § 1395 *et seq.*, provides for judicial review "after such hearing as is provided in section 405(g) of this title", 42 U.S.C. § 1395ff, and the Supreme Court has read § 405(g) as imposing two prerequisites to judicial review. The first is that the plaintiff present a claim for the benefits to the Secretary (who, the parties agree, is here represented by the fiscal intermediaries who make initial payment determinations on his behalf). The second is that the plaintiff exhaust all administrative remedies available after an initial denial. The Court has said that the presentment requirement is not "waivable" but that the exhaustion requirement is. *Mathews v. Eldridge*, 424 U.S. 319, 328-30 (1976); *Weinberger v. Salfi*, 422 U.S. 749, 763-65 (1975). The Secretary argues that none of the members of the certified class has satisfied both requirements (or, in the case of exhaustion, qualified for "waiver").

A.

As to presentment, the members of the certified class fall into three groups: (1) all plaintiffs, named and unnamed, who have already presented claims for and have been denied SNF coverage because of the Secretary's reading of § 101(b)(1)(C) ("claimants"); (2) all unnamed plaintiffs who have not yet presented a claim for coverage but will do so in the future and "will be denied" coverage — or would be denied, but for the litigation — ("future claimants"); and finally, (3) all unnamed plaintiffs who have not presented a claim for coverage and will never do

so, but who nevertheless would be denied coverage because of the Secretary's view ("nonclaimants"). Of these three, plaintiffs in the first group (including all the named plaintiffs) have clearly met the nonwaivable presentment requirement, and are entitled to judicial review unless defeated by their failure to exhaust.

As to future claimants, the Supreme Court has sent mixed signals. In *Mathews v. Diaz*, 426 U.S. 67 (1976), it noted that the district court had erroneously certified a class including individuals who "will be denied" the benefits sought. The Court explained that "[t]hose who 'will be denied' enrollment . . . are those who have yet to be denied . . . ." As the record did not show "any action with respect to such persons that is tantamount to a denial", the district court lacked jurisdiction over their claims. *Id.* at 71-72 & n.3.

But in *Califano v. Yamasaki*, 442 U.S. 682 (1979), the Court appeared to approve a class partially composed of future presenters (in the specific context, future filers of requests for reconsideration or waiver). The district courts had certified classes that included persons who had neither presented their claims in the past *nor* would do so in the future. *Id.* at 704. The Court characterized this class certification as "plainly too broad", *id.*, as it included individuals who *never would* present a claim (nonclaimants, in the terms of this case). But the court of appeals had framed its holding as entitling claimants to a hearing " 'when they claim a waiver [i.e., present their claims].' " As claimants could enjoy the remedy only by "filing a written request with the Secretary," the Court said that only persons meeting the jurisdictional prerequisites would get relief. *Id.* Thus, without mentioning *Diaz*, the Court appeared to approve a class including persons who had not yet satisfied § 405(g) but would ultimately do so. See also *Dixon v. Heckler*, 589 F. Supp. 1494, 1512 (S.D.N.Y. 1984), *aff'd* 785 F.2d 1102 (2d Cir. 1986), *vacated on other grounds sub nom. Bowen v. Dixon*, 482 U.S. 922 (1987); *Stieberger v. Heckler*, 615 F. Supp. 1315, 1329 (S.D.N.Y. 1985). As the court pointed out in *Dixon*, this result is

consistent with the practice of defining classes to include persons who will in the future fit the class criteria. See *Dixon*, 589 F. Supp. at 1512 (citing *Brown v. Board of Education*, 84 F.R.D. 383, 394 (D. Kan. 1979) (treating class of applicants to elementary school as extant 28 years after suit began, as class at outset included future members)). We need not address the issue of a class consisting only of persons who will in the future satisfy § 405(g)'s presentment requirement.

This leaves the third group of potential plaintiffs—nonclaimants. The appellees argue that the presentment requirement should be generically deemed satisfied because (1) some potential claimants received no notice of any right to claim benefits despite their want of a three-day hospital stay, and (2) others received a notice that appellees argue contained "crucial misinformation". Appellees' Brief at 17. Specifically, the appellees argue that the Model Letter sent out by the Secretary for distribution by SNFs to their patients misled them as to the source of their benefit denial. The Model Letter said:

> On (*date*), we reviewed your records in light of the recent Medicare SNF benefit changes, and we decided that (*you or beneficiary's name*) did not meet the reinstated post-hospital requirement for SNF coverage under Medicare, and did not qualify for an exemption from this requirement. Therefore, as of January 1, 1990, Medicare cannot cover your SNF care.
>
> This decision has not been made by Medicare. This decision is our judgment that you did not meet the Medicare post-hospital requirement. Normally in this situation, we do not submit a bill to Medicare. We will submit a bill to Medicare only if you request it. Furthermore, if you want to appeal this decision, you must request that a bill be submitted. If you request that a bill be submitted, the Medicare intermediary will review your records and notify you of its determination. If you disagree with that determination, you may file an appeal.

J.A. at 105-06.

The Supreme Court's repeated characterizations of presentment as not "waivable" suggest that no such exception for inadequate notice exists, as does the *Yamasaki* opinion's cursory rejection, as "plainly too broad", of a class containing persons who would not present their claims in the future. See *Yamasaki*, 442 U.S. at 704. But we need not here explore the existence or scope of any such exception. First, the sole claimant identified as receiving *no* notice has in fact presented her claim. See Appellees' Brief at 13 (all named plaintiffs presented their claims); J.A. at 62-69 (papers relating to plaintiff Corinne Dickinson). Without more evidence of want of notice, we see no need to address this speculative issue. Second, while the Model Letter does not give a complete picture of the reasons for denial and the avenues of redress, we doubt if any letter that would be meaningful for most Medicare applicants could possibly do so. The Model Letter makes clear (1) that there is a post-hospital stay requirement imposed from on high; (2) that the SNF believes the patient has not met the requirement; and (3) that the patient may press the claim with the fiscal intermediary. Any patient who doubted the validity of the post-hospital stay requirement would presumably think that the solution was first to ask the fiscal intermediary for relief, as in fact it was. We see no basis for holding, as appellees implicitly ask, that presentment is excused unless the notice explicitly enumerates all the arguable interpretive premises of the finding of unavailability and tells patients that each of these may be challenged before the fiscal intermediary.

B.

As plaintiffs make no claim that any of their number exhausted their remedies from denial by the fiscal intermediaries, they can secure judicial review only if the exhaustion requirement is excused. In the Supreme Court's first treatment of this subject, *Weinberger v. Salfi*, 422 U.S. 749, 767 (1975), the agency had raised no exhaustion defense, and the Court's characterization of

the result as a "waiver" was a conventional use of the term. Since then, the Court has extended the term to situations where the Secretary staunchly demands that the claim be dismissed for want of exhaustion, but the Court itself has excused non-compliance. The main cases are *Mathews v. Eldridge*, 424 U.S. 319, 328 (1976); *Mathews v. Diaz*, 426 U.S. 67, 76-77 (1976); and *Bowen v. City of New York*, 476 U.S. 467, 483 (1986).

The cases proceed against the backdrop of *Salfi*'s observation that § 405(g)'s requirement of a "final decision" was "more than simply a codification of the judicially developed doctrine of exhaustion, and may not be dispensed with merely by a judicial conclusion of futility . . . ." 422 U.S. at 766. As a result, two of the three major cases excusing exhaustion post-*Salfi* (*Eldridge* and *City of New York*) have rested on futility *plus* some version of the "collateral order" exception to finality established for federal appellate review by *Cohen v. Beneficial Loan Corp.*, 337 U.S. 541 (1949). See *Eldridge*, 424 U.S. at 331 n.11 (citing *Cohen*). *Diaz*, however, is a pure futility case, and we believe it applicable here.

Although the Secretary invoked want of exhaustion in *Diaz*, he stipulated that no facts were in dispute, that the case was ripe for disposition by summary judgment, and that the only issue was the constitutionality of the statute — an attack on a durational residence requirement. 426 U.S. at 76. The Secretary had stated twice in Supreme Court filings that the applicant's request for benefits would be denied on the basis of the requirement. *Id.* The Court characterized the stipulation in the district court "as tantamount to a decision denying the application and as a waiver of the exhaustion requirements." *Id.* at 77.

Here, the plaintiffs ask for a declaration that the Secretary's reading of § 101(b)(1)(C) was invalid and an injunction against his denying Medicare reimbursement for SNF patients who would be eligible once the allegedly erroneous interpretation is swept away. It is hard to see how any factual disputes might stand in the way of that relief,

and the Secretary suggests none. And, although the legal issue is statutory rather than constitutional, so that the Secretary has *authority* to decide the legal issue in plaintiffs' favor, compare *Diaz*, 426 U.S. at 76 (noting that the constitutional claim was beyond the Secretary's competence), the Secretary gives no reason to believe that the agency machinery might accede to plaintiffs' claims. He does not argue that ALJs are free to disregard his ruling, and he acknowledged at oral argument that review by the Appeals Council, apparently the next and final level of appeal, was in essence review by the Secretary himself. On this record, it seems wholly formalistic not to regard further appeals as completely futile.

Rather than offering any reason to doubt futility, the Secretary cites *Heckler v. Ringer*, 466 U.S. 602 (1984), where the Court refused to excuse want of exhaustion even though plaintiffs purported to attack the Secretary's systemwide interpretation of the statute as not authorizing reimbursement for a specific medical procedure. But there was ample reason for the Court's refusal to find futility in *Ringer*. Three of the four plaintiffs were not covered by the systemwide decision, as they had had the procedure before its effective date. As to them, there was no reason to suppose that the Secretary's policy declaration would bar recovery, and thus none to suppose that exhaustion was futile. 466 U.S. at 618-19 & n.12. The fourth plaintiff had not yet had the operation. Section 405(g) blocked his claim, the Court found, because the statute plainly barred pre-operation advisory opinions even by the Secretary, and the Court declined to "undercut that choice by allowing federal judges to issue such advisory opinions." *Id.* at 621-22.

Our finding of futility is by its nature a finding that dispensing with further administrative process is consistent with the purposes of exhaustion. In *Salfi* the Court set these forth as follows:

> Exhaustion is generally required as a matter of preventing premature interference with agency processes, so that the agency may function efficiently

> and so that it may have an opportunity to correct its own errors, to afford the parties and the courts the benefit of its experience and expertise, and to compile a record which is adequate for judicial review.

422 U.S. at 765. Here, judicial resolution of the statutory issue (1) will not interfere with the agency's efficient functioning; (2) will not thwart any effort at self-correction; (3) will not deny the court or parties the benefit of the agency's experience or expertise; and (4) will not curtail development of a record useful for judicial review.

Because we believe our finding of futility to be nearly as firmly grounded as that of *Diaz*, we follow *Diaz* in not addressing the collateral order exception. We note that the doctrine at its outset appeared to be quite narrow, like that of *Cohen v. Beneficial Loan Corp.* itself. In *Eldridge* the Court emphasized that the particular claim raised — entitlement to a predeprivation hearing as a matter of right — "rest[ed] on the proposition that full relief cannot be obtained at a postdeprivation hearing." 424 U.S. at 331. In *City of New York*, however, the Court appeared to loosen the doctrine, reasoning that insistence on exhaustion would impose irreparable injury because the ordeal of going through the administrative process might "trigger a severe medical setback", and that indeed persons had been hospitalized because of the trauma of having disability payments cut off. 476 U.S. at 483. Such hazards seem generic to Medicare claims, and indeed similar ones are urged here. As the findings of futility in both *Eldridge* and *City of New York* were relatively weak compared to those of *Diaz*, see *Eldridge*, 424 U.S. at 330; *City of New York*, 476 U.S. at 485, we infer that collateral order arguments may serve to help excuse exhaustion where futility alone is not enough. Because of the similarity of our case to *Diaz*, however, we do not try to determine the exact relationship.

III.

At last we reach the merits. Here, as usual, we look to *Chevron U.S.A. Inc. v. Natural Resources Defense Council*,

467 U.S. 837 (1984), and inquire whether Congress "has directly spoken to the precise question at issue", *id.* at 842. If so, "that is the end of the matter." *Id.* If not, we inquire whether the agency in charge of administering the statute has given it a "permissible construction", *id.* at 843, for we may not substitute our view "for a reasonable interpretation" made by the agency, *id.* at 844.

For convenience, we repeat the relevant text:

> (b) **Transition provisions for Medicare beneficiaries. —(1) Inpatient hospital services and post-hospital extended care services.**—In applying [42 U.S.C. §§ 1395d and 1395e], as restored by subsection (a)(1) [of the Repeal Act], with respect to inpatient hospital services and extended care services provided on or after January 1, 1990—
>
> > (A) no day before January 1, 1990, shall be counted in determining the beginning (or period) of a spell of illness;
> >
> > . . .
> >
> > (C) the limitation of coverage of extended care services to post-hospital extended care services shall not apply to an individual receiving such services from a skilled nursing facility during a continuous period beginning before (and including) January 1, 1990, until the end of the period of 30 consecutive days in which the individual is not provided inpatient hospital services or extended care services . . . .

Pub. L. No. 101-234, § 101(b)(1), 42 U.S.C. § 1395e note.

At first blush, the language of § 101(b)(1)(C) seems to support the plaintiffs' interpretation. It exempts from the post-hospital stay requirement any "individual receiving such ["extended care"] services from a skilled nursing facility during a continuous period beginning before (and including) January 1, 1990 . . ."; it does not expressly mention entitlement to a Medicare subsidy on December 31, 1989 as a further qualification for exemption. Read with-

out inquiry into context, the provision appears unambiguous.

The Secretary identifies an ambiguity in § 101(b)(1)(C) itself. "[S]uch services" could refer either to "post-hospital extended care services", which is the immediate prior reference to services, or to SNF services regardless of prior hospital stays. But as the Secretary himself goes on to note, *that* ambiguity is easily resolved; a person receiving extended care services that are "post-hospital" has no need of any transition provision on that issue, so the more general usage must be intended. The force of the ambiguity, once resolved, is largely spent. Contrary to the government's implicit suggestion, the presence of a single, readily cured ambiguity in a clause does not render it ambiguous on every other interpretive issue. The asserted ambiguity shows only that Congress did not draft the clause with mathematical precision.

Thus plaintiffs regard § 101(b)(1)(C) as so clear that we need inquire no further. They quote, for example, Justice Scalia's emphatic statement in *West Virginia University Hospitals, Inc. v. Casey*, 111 S. Ct. 1138 (1991):

> The best evidence of [congressional] purpose is the statutory text adopted by both Houses of Congress and submitted to the President. Where that contains a phrase that is unambiguous—that has a clearly accepted meaning in both legislative and judicial practice—we do not permit it to be expanded or contracted by the statements of individual legislators or committees during the course of the enactment process.

Id. at 1147. For other recent cases of similar tenor, see *Demarest v. Manspeaker*, 111 S. Ct. 599, 604 (1991); *United States v. Ron Pair Enterprises, Inc.*, 489 U.S. 235, 241 (1989).

But while the immediate statutory text is the "best evidence" of congressional intent, the Court has never held that it is the *only* such evidence. To the contrary, it has repeatedly said that congressional intent can be

understood only in light of the context in which Congress enacted a statute and of the policies underlying its enactment. See, e.g., *McCarthy v. Bronson*, 111 S. Ct. 1737, 1740 (1991) (Court relies on context to reject "the most natural reading" of a statutory phrase); *Crandon v. United States*, 494 U.S. 152, 158 (1990) ("In determining the meaning of the statute, we look not only to the particular statutory language, but to the design of the statute as a whole and to its object and policy."); *Associated General Contractors v. California State Council of Carpenters*, 459 U.S. 519, 530 (1983) ("A proper interpretation of the section cannot ... ignore the larger context in which the entire statute was debated.").

Moving beyond § 101(b)(1)(C) itself, we find the caption of § 101(b), "Transition provisions for Medicare beneficiaries", making clear that transition benefits are to be available for beneficiaries. Under the plaintiffs' reading, subsection (C) creates an entitlement on the basis of mere *recipient* status on the controlling date (December 31, 1989). This creates at least some tension with the caption, even though, of course, the relevant non-beneficiary recipients as of that date would *have been* beneficiaries earlier in the year. At any rate, the reference to "beneficiaries" in the caption provides some support for the Secretary's view that in referring to recipients Congress likely *assumed* beneficiary status at the critical moment.

Moreover, the disputed phrase appears as part of a subsection, § 101(b), that is self-evidently devoted to special problems of transition back to the *status quo ante* the Catastrophic Coverage Act. Such grandfathering typically seeks to provide special relief for persons on whom the new regime might bear with unusual severity, because it specially disrupts their lives, usually because of decisions they are likely to have taken in reliance on the prior regime. See, e.g., *Sercl v. United States*, 684 F.2d 597, 599 (8th Cir. 1982) ("Although the revenue ruling does not explicitly specify the purpose of the grandfather clause, the most logical explanation for it is to protect taxpayers

who acted in reliance on the prior, revoked ruling."); cf. *Heckler v. Mathews*, 465 U.S. 728, 743-46 (1984) (noting that purpose of limited exemption was to protect expectations developed before the Court's decision in *Califano v. Goldfarb*, 430 U.S. 199 (1977), subject to constraint of preventing major drain on Social Security trust funds).

We have already noted how subsection (A) serves typical grandfathering purposes, excluding any SNF days in 1989 from the computation of a "spell of illness" and thereby protecting patients who may have continued in a SNF longer than otherwise in partial reliance on the Catastrophic Coverage Act's allowance of 150 days.[4] It puts all who used Catastrophic Coverage Act benefits on a par with patients getting sick January 1, 1990, in the sense that a patient's enjoyment of past entitlements will not count against him.

While subsection (A) relieves a patient of possible *adverse consequences of having used benefits* under the Catastrophic Coverage Act, § 101(b)(1)(C) — under both competing constructions — goes further. It affirmatively entitles a class of Catastrophic Coverage Act beneficiaries to post-1989 coverage despite failure to satisfy the resurrected pre-1989 criterion of a prior hospital stay. In the Secretary's view, it affords this advantage only to patients actually enjoying Medicare-subsidized service at the moment of transition, whereas under plaintiffs' it protects patients in a SNF on December 31, 1989, even though their coverage has already run out.

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[4]Subsection (A) protects not only patients who used their 150 days under the Catastrophic Coverage Act but also those who stayed longer, without government support. This might suggest congressional readiness to protect a very weak form of reliance, namely continued use of *un*subsidized SNF services in anticipation of a fresh start, per the Catastrophic Coverage Act, on January 1, 1990. But any patient in this position who benefits from subsection (A) will already have engaged in the strong form of reliance on the Catastrophic Coverage Act — use of the actual subsidy for 50 days longer than under the prior regime.

Plaintiffs' reading seems broad in relation to conventional grandfathering goals. For the extra patients covered by plaintiffs' interpretation (but not by the Secretary's), presence in the SNF at year end seems hard to attribute to the fact of the Catastrophic Coverage Act's having more expansive terms than the earlier regime; they were there *in spite of* coverage's having run out *even* under the Catastrophic Coverage Act regime. Conceivably some may have remained in the SNF longer than they otherwise would have, in anticipation of the resumption of coverage. But as their presence in the SNF after the allowed 150 days must have had non-Medicare sources of financing, any such reliance would have been highly attenuated.

Transition provisions could, of course, be yet more protective than even plaintiffs argue. Congress could have provided that anyone who received any Catastrophic Coverage Act benefits in 1989 would continue to be eligible under that regime. But as such protection would be far broader than any coverage based on reliance, dependency or disruption, it would seem prima facie unlikely. Plaintiffs' reading of § 101(b)(1)(C) encounters a similar problem.

Even if these contextual concerns left the language of § 101(b)(1)(C) superficially clear, legislative history may call such apparent clarity into question. In *Associated General Contractors*, for example, the Court said that while a "literal reading" of a statute giving standing to any person "injured" by an antitrust violation was "broad enough to encompass every harm" due to such a violation, it was necessary first to consider "whether Congress intended such an open-ended meaning." *Id.* at 529-30. Consulting the legislative history, it found standing to be far more limited than the literal wording of the statute alone would have suggested. *Id.* at 530. Similarly, in *United States v. Shirey*, 359 U.S. 255, 256-60 (1959), the Court considered the legislative history of a statute prohibiting the purchase and sale of public offices and concluded that the Republican Party was a "person" for the

purposes of the statute's application, *id.* at 257 n.2, though the statutory language alone would not have suggested such a meaning. See also *Inner City Broadcasting Corp. v. Sanders*, 733 F.2d 154, 158 (D.C. Cir. 1984) ("*[U]nless contrary indications are present*, a court can assume that Congress intended the common usage of the term to apply.") (emphasis added); *Alabama Power Co. v. Costle*, 636 F.2d 323, 396 (D.C. Cir. 1979) ("*Given no expression of any contrary intent in the Act or in the legislative history regarding [its meaning]*, we must assume that the meaning of a particular term is to be consistent throughout the Act.") (emphasis added).

The legislative history of the transition provision reveals a purpose consistent with conventional grandfathering goals. There being no pertinent references in the committee reports, we turn to statements by both the House and the Senate sponsors of the bill, normally the next-highest ranked form of legislative history. *NLRB v. Fruit & Vegetable Packers & Warehousemen, Local 760*, 377 U.S. 58, 66-67 (1964); *Lewis v. Sporck*, 612 F. Supp. 1316, 1330 (N.D. Cal. 1985). All of these indicate an intent to use § 101(b)(1)(C) to exempt from the post-hospital requirement individuals who were, as of December 31, 1989, receiving SNF *coverage*. Representative Donnelly, in a rather formal statement captioned "Technical Description of the Catastrophic Coverage Repeal Act of 1989", 135 Cong. Rec. H5125 (Aug. 4, 1989), stated:

> The bill repeals all benefits generally effective on January 1, 1990. However, to the extent that a beneficiary is receiving benefits under the bill on that date, the beneficiary is generally held harmless.

Id.

Plaintiffs point to the phrase "under the bill", and read the comment as merely saying that there will *be* patients who receive benefits under the transition provision of *the Repeal Act* itself. Appellees' Brief at 40. Thus, in their view, Representative Donnelly devoted a sentence to explaining that persons who received benefits under the

transition provision would receive benefits under the transition provision. Surely his colleagues did not need him to enable them to grasp that truth.[5] We think it more plausible that Representative Donnelly was communicating the thought that the transition provision protected patients who were receiving benefits under the Catastrophic Coverage Act at the moment of transition.[6]

Similarly, Senator Roth explained: "To put it simply, this amendment repeals all current and future catastrophic benefits except for some transition rules that help

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[5]Representative Donnelly went on to say:

> Thus, if a beneficiary was hospitalized in 1989, the days of hospitalization in that year are not treated as a spell of illness. In addition, a beneficiary who is hospitalized on January 1, 1990 will not have to pay a second deductible during that spell of illness.

135 Cong. Rec. H5125. Plaintiffs believe these two sentences support their view that *coverage* on December 31, 1989 is not essential for a patient to receive the benefits of § 101(b)(1)(C). But the first sentence clearly refers to the relation between the Catastrophic Coverage Act's 150-day rule and the revived spell-of-illness requirement, a grandfathering that, as we have explained, is for good reason independent of status on that date. The second sentence evidently refers to § 101(b)(1)(D)(i), which relieves patients of a deductible triggered by each new spell of illness and uses language similar to that of § 101(b)(1)(C) — "an individual who is receiving inpatient hospital services during a continuous period beginning before (and including) January 1, 1990 . . . ." Plaintiffs assume, perhaps correctly, that this clause covers persons whose Catastrophic Coverage Act coverage had run out before year's end, but the context is quite different, as relief from the deductible is a natural extension of the pre-Catastrophic Coverage Act principle of imposing only one deductible for any single continuous period in a SNF.

[6]After enactment of the Repeal Act, Representative Donnelly explained in a letter to Michael Astrue, General Counsel for the Department of Health and Human Services, his view of the transition provision. Donnelly Letter, December 21, 1989, J.A. at 86-87. Because of its post-enactment character, we attach no weight to the letter. *Multnomah Legal Services Workers Union v. Legal Services Corp.*, 936 F.2d 1547, 1555 (9th Cir. 1991).

accomplish repeal *in a manner that is not disruptive to individuals currently receiving benefits*." 135 Cong. Rec. S12882 (daily ed. Oct. 6, 1989) (emphasis added). Plaintiffs explain this away by reading "currently" to refer to receipt of benefits any time in the then current year, i.e., the year covered by the Catastrophic Coverage Act. Appellees' Brief at 42. But it would be odd indeed to speak of "disrupt[ion]" for persons whose benefits clearly ended before December 31, 1989 and might well have ended in May. We find the Secretary's reading far more natural.

The Secretary also points to a remark of a Senate cosponsor, Senator Coats: "The intent is to insure that no Medicare beneficiary will be forced out of a hospital room or nursing home bed due to repeal." 135 Cong. Rec. S12887 (daily ed. Oct. 6. 1989). This indeed seems to support the Secretary's reading of § 101(b)(1)(C), under which only persons whose presence in a SNF on December 31, 1989 was *not* supported by Medicare would be denied Medicare support by virtue of failing the post-hospital stay requirement. It seems a stretch to regard such a person, supported by alternative sources on December 31, 1989, as "forced out" by the Repeal Act's failure to *revive* benefits on January 1, 1990. Plaintiffs' counsel suggest that a patient may be "forced out" under the Secretary's reading, pointing to a plaintiff whose coverage ended before December 31, 1989 but who had "Medigap" insurance taking her through to year's end, but not covering the next year. Appellees' Brief at 43-44. But all this means is that Medigap coverage premised on plaintiffs' reading of the Repeal Act would prove incomplete under the Secretary's. Though perfectly true, the point hardly supports denying Senator Coats's statement the more apparent reading.

Finally, the Secretary rests in part on a one-page computer print-out, of which we append a photocopy and which we will refer to as the "CBO Exhibit", although, in truth, its provenance is unclear. Footnote 1, which is flagged at a reference to $200 million for SNF costs in 1990, states: "SNF as Donnelly/Archer effective 1/1/90.

Assumes that only 1990 transition SNF costs ($200 million) are funded by catastrophic premiums." Another line notes $900 million for 1990 SNF; as it is totalled with the prior reference to $200 million, we infer that the author saw the $900 million as additional to the "1990 SNF transition costs ($200 million)". J.A. at 85. Further, Representative Archer, urging enactment of repeal (with his transition provisions), argued that Congress could not, as a matter of politics or good policy, "transfer[ ] the cost of the program from the beneficiaries to the taxpayers." 135 Cong. Rec. H6584 (daily ed. Oct. 4, 1989). All this is connected to our problem by an affidavit by Solomon Mussey, Director of the Office of Medicare Cost Estimates, Office of the Actuary of the Health Care Financing Administration, stating that he had estimated transition SNF costs immediately after enactment, using first the Secretary's interpretation, then the one (later) adopted by plaintiffs. He estimated costs at $230 million under the Secretary's view, but at $690 million under the plaintiffs'. J.A. at 88-89. If Congress intended transition costs to be largely covered by unexpended Catastrophic Coverage Act premiums (apparently $200 million), a reading that will cost more than triple that amount is questionable.

We find the CBO Exhibit perplexing. Except for the probably computer-driven date and time, it has no caption. There is no clue what members of Congress might have received it. Further, the second reference to SNF costs estimates $900 million for 1990 and $300 million for each of the next two years; from this one might infer that *some* 1990 transition costs are to be borne by the taxpayer, with $300 million being the "regular" SNF costs, i.e., those to be expected to be incurred each year once the "transition" is over.

Surprisingly, appellees make none of these arguments. Instead, they point to another CBO estimate, this one published ([1990 Transfer Binder] CCH Medicare & Medicaid Guide (CCH) ¶ 38,052), stating that *under the Catastrophic Coverage Act* 1990 SNF costs would have been about $2.5 billion in 1990. So, they say, even under their

reading the Repeal Act saved about $1.7 billion. See Appellees' Brief at 45-46. Whatever the frailties of the Secretary's view of the CBO Exhibit, his inferences are not undermined by this. The Act repealed a large tax precisely because the targeted taxpayers found it burdensome, and sought to match the tax repeal with parallel expenditure reductions. In the face of evidence that under plaintiffs' reading the transition provision would cost more than *triple* the estimate, it is no answer to say that, even so, the Repeal would cost a lot less than the Catastrophic Coverage Act. Because of the vulnerabilities of the CBO Exhibit not raised by plaintiffs (perhaps not raised because there are good answers), we cannot give it much weight, but as plaintiffs raise only a frivolous objection, we believe it relevant and somewhat supportive of the Secretary.

* * *

All of this takes us only to the conclusion that Congress has not "spoken directly to the precise question at issue". But the same circumstances that undermine plaintiffs' view that their literal reading represents Congress's "clear" intent, see *Chevron*, 467 U.S. at 842, also support the reasonableness of the Secretary's view: it is more in harmony both with traditional grandfathering notions and with the legislative history. Accordingly, the decision below is

Reversed.

11/17/89
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PROVISIONS	1989	1990	1991	1992	1993	1994	1990-94 TOTAL
I. SPENDING							
Hospital	893	1293	1401	1522	1659	1803	7678
SNF (1)	0	200	0	0	0	0	200
Home Health	0	129	183	194	208	223	937
Blood Deductible	6	9	10	11	12	12	54
Hospice	1	1	1	1	1	1	5
Part B Copay Cap	0	0	0	0	0	0	0
Respite	0	12	30	48	77	122	289
Screening Mammography	0	75	123	138	147	156	639
Home IV/Immune Drugs	0	0	0	0	0	0	0
Other Drugs	0	0	0	0	0	0	0
Administrative Costs	160	46	56	59	61	64	286
Subtotal Spending	1060	1765	1804	1973	2165	2381	10088
SNF Spending	900	900	300	300	400	400	2300
TOTAL MEDICARE SPENDING	1960	2665	2104	2273	2565	2781	12388
II. INCOME COMPONENT							
Flat Premium	1165	1790	1957	2044	2219	2397	10408
Supplemental Premium (non-add)	531	−531	0	0	0	0	−531
TOTAL MEDICARE INCOME	1165	1790	1957	2044	2219	2397	10408
NET MEDICARE (Outlays-Income)	795	875	147	229	346	384	1980
NET MEDICARE WITHOUT SNF	−105	−25	−153	−71	−54	−16	−320
III. TRUST FUND INFORMATION(2)							
Calendar Year Monthly Premium	$4.00	$4.70	$4.90	$5.00	$5.40	$5.80	
End of Year Balance	197	199	346	406	467	512	
Contingency Margin (EDY Balance/Same Year's Outlays)	14%	11%	19%	20%	21%	21%	

SOURCE: CONGRESSIONAL BUDGET OFFICE, AUGUST BASELINE

(1) SNF as Donnelly/Archer effective 1/1/90. Assumes that only 1990 transition SNF costs ($200 million) are funded by catastrophic premiums.

(2) The premium is set to fully fund program costs with an appropriate contingency margin.

BUCKLEY, *Circuit Judge, dissenting*: It is axiomatic that in interpreting a statute, a court must begin with its language. It should also be clear by now that when that language answers the question before the court, there is no need to go further: "[W]here . . . the statute's language is plain, 'the sole function of the courts is to enforce it according to its terms.' " *United States v. Ron Pair Enterprises, Inc.*, 489 U.S. 235, 241 (1989) (quoting *Caminetti v. United States*, 242 U.S. 470, 485 (1917)). The question here is whether section 101(b)(1)(C) of the Medicare Catastrophic Coverage Repeal Act of 1989 ("Repeal Act") can be read to support the Secretary's effort to limit its coverage to only those persons who (1) received extended care services from a skilled nursing facility ("SNF") for a continuous period beginning before and including January 1, 1990 and (2) *also* received medicare benefits for those services on December 31, 1989 and January 1, 1990. As I find it cannot, I would affirm the district court's decision on the merits. I agree, however, with the panel's treatment of the district court's class certification order and would remand solely for the purpose of recertifying a proper class.

As my colleagues recognize, subsection (1)(C) of the transition provisions, standing alone, is not ambiguous. *See* Maj. Op. at 14-15. The subsection states:

> (1) *Inpatient hospital services and post-hospital extended care services.*—In applying sections 1812 and 1813 of the Social Security Act, as restored by subsection (a)(1), with respect to inpatient hospital services and extended care services provided on or after January 1, 1990—
>
> ***
>
> (C) the limitation of coverage of extended care services to post-hospital extended care services shall not apply to an individual receiving such services from a skilled nursing facility during a continuous period beginning before (and including) January 1, 1990, until the end of the period of 30 consecutive days in

> which the individual is not provided inpatient hospital services or extended care services ....

Pub. L. No. 101-234, § 101(b)(1)(C). On its face, the language "allows for only one reasonable construction." *Tataranowicz v. Sullivan*, 753 F. Supp. 978, 984 (D.D.C. 1990). The provision establishes just one requirement: an individual must have received extended care services from an SNF during the transition period. There is not the slightest intimation, in subsection (1)(C), that Congress intended to add the second part of the test imposed by the Secretary. Under the traditional analysis of *Chevron U.S.A. Inc. v. NRDC*, 467 U.S. 837, 842 (1984), because Congress "has directly spoken to the precise question" of who should benefit from the transition provision, the Secretary may not substitute his judgment for that of Congress.

I recognize that the Supreme Court has found ambiguity to exist in instances where a literal reading of a facially clear statute would conflict with a pre-existing "pervasive regulatory scheme," *Train v. Colorado Public Interest Research Group*, 426 U.S. 1, 24 (1976), or where a provision is rendered ambiguous by other parts of the statute. See *McCarthy v. Bronson*, 111 S. Ct. 1737, 1740 (1991). No such contradictions exist in this case, however, and the majority points to no precedent in which the Supreme Court or this court has found clear statutory language ambiguous on such slender reeds as the ones on which it relies.

My colleagues assert that the title heading preceding the transition provisions in the Repeal Act renders section 101(b)(1)(C) unclear. Section 101(b) is captioned: "Transition Provisions for Medicare Beneficiaries." They are, however, somewhat at a loss to explain how the presence of that caption makes subsection (C) any less clear. *See* Maj. Op. at 16 (clear meaning of the statute "creates at least some tension with the caption"). They also recognize that the term "beneficiaries" could refer to anyone who was a beneficiary during 1989. *Id.* Their difficulty

illustrates why a subheading should not be used to create ambiguity in statutory language. The Supreme Court has cautioned that

> [w]here . . . text is complicated and prolific, headings and titles can do no more than indicate the provisions in a most general manner . . . . As a result, matters in the text which deviate from those falling within the general pattern are frequently unreflected in the headings and titles. Factors of this type have led to the wise rule that the title of a statute and the heading of a section cannot limit the plain meaning of the text. For interpretative purposes, they are of use only when they shed light on some ambiguous word or phrase.

Brotherhood of R.R. Trainmen v. Baltimore & Ohio R.R. Co., 331 U.S. 519, 528-29 (1947) (citations omitted). *See also NRDC v. EPA*, 915 F.2d 1314, 1321 (9th Cir. 1990) (statutory headings "cannot *create* an ambiguity where none otherwise would exist") (emphasis in the original); *cf. Utah Power & Light Co. v. ICC*, 747 F.2d 721, 727 (D.C. Cir. 1984) (statutory title can indicate legislative intent where statutory term ambiguous). As the statutory language is clear, the caption is irrelevant.

Next, the majority suggests that the transition provisions are

> self-evidently devoted to special problems of transition back to the *status quo ante* the Catastrophic Coverage Act. Such grandfathering typically seeks to provide special relief for persons on whom the new regime might bear with unusual severity, because it specially disrupts their lives, usually because of decisions they are likely to have taken in reliance on the prior regime.

Maj. Op. at 16. Accepting that it is self-evident that the provisions "provide special relief" for those peculiarly affected by the change in regimes, the majority fails to explain why the plaintiffs do not fall within that purpose.

If the Catastrophic Coverage Act of 1988 had remained in force, individuals who had exhausted their 150 days of

coverage in 1989 but remained in their SNFs would have begun receiving benefits again on January 1, 1990. That was their expectation at least until December 13, 1989, when the President signed the Repeal Act into law. It is beyond dispute that the elderly in our society must structure their use of medical services to take advantage of any source of financing. Many class members moved into SNFs in 1989 without spending three days in a hospital prior to admission. *See* Exhibits A and L to Plaintiffs' Reply to Defendant's Motion to Dismiss, *reprinted in* Joint Appendix at 31, 78-81; Exhibit A to Plaintiffs' Motion for Summary Judgment; Exhibit A to Plaintiffs' Motion and Memorandum for a Reduction of Time for Defendant to Respond to Complaint of Applicant for Intervention. At least one member of the class spent the requisite three days in a hospital, returned home for over thirty, and then moved to a nursing facility. *See* Exhibit A to Plaintiffs' Motion for a Reduction of Time. It appears that another relied on the availability of benefits for the first part of 1990 to trigger a "medigap" insurance policy that would then cover the remainder of the year. *See* Joint Appendix at 78-81; Brief for Appellees at 44.

The abrupt return to the old system certainly upset the planning of these individuals and would inflict a significant hardship on them. Rewriting subsection (1)(C) to exclude these persons would implicate the reliance factor that the majority views as the target of the transition provision. Thus, it is anything but self-evident that Congress would have wanted to deprive them of its benefits.

The majority nevertheless contends that this vision of congressional intent "seems broad in relation to conventional grandfathering goals." Maj. Op. at 18. Perhaps, then, Congress had broader purposes than the one the majority feels appropriate. Another transition provision, section 101(b)(1)(D)(ii), suggests that Congress sought to achieve more than "conventional grandfathering" as defined by the majority. Under that provision, the Social Security Act's inpatient hospital deductible would not apply "for a spell of illness beginning during January

1990, if such a deductible was imposed on the individual for a period of hospitalization that began in December 1989 ...." Pub. L. No. 101-234, § 101(b)(1)(D)(ii). This transition provision provides generous treatment for individuals who entered a hospital in December 1989, terminated their stay in that month, and then returned to a hospital in January 1990. Such individuals need not pay the annual deductible for 1990. Whatever the objective of that provision, it cannot be to "grandfather" a rule applicable to persons receiving medicare coverage for services at the time of the Repeal Act's passage.

The majority also derives ambiguity from the legislative history, placing particular reliance on statements from sponsors and cosponsors of various versions of the Repeal Act. Even when clear, however, such statements are unreliable guides to statutory meaning. "While a sponsor's statements may reveal *his* understanding and intentions, they hardly provide definitive insights into *Congress'* understanding of the meaning of a particular provision." *Overseas Educ. Ass'n, Inc. v. FLRA*, 876 F.2d 960, 975 (D.C. Cir. 1987) (Buckley and Starr, JJ., concurring) (emphasis in original). As any viewer of C-SPAN knows, such explanations often fall on few, if any, ears.

Finally, the majority seeks support for its holding from a one-page computer print-out that purports to give cost estimates of the Congressional Budget Office for the Repeal Act. My colleagues effectively undermine the value of this evidence, Maj. Op. at 21-22, yet they consider it "relevant and somewhat supportive of the Secretary," *id.* at 23, simply because appellees did not make the same arguments. I read appellees' brief, however, as questioning the relevance of the estimate and whether any member of Congress relied on it. *See* Brief for Appellees at 44-45. In any event, we are not bound, when interpreting a statute, to rely on the arguments put before us by the parties. Indeed, the Secretary makes no claim, for example, that the transition provision serves "conventional grandfathering goals," yet the panel overturns the district court based, in part, on that argument.

Having reached the conclusion that Congress could not have meant what it clearly said, the majority has jerry-built the suggestion of a contrary intent out of "evidence" that, on examination, proves to be little more than attenuated inferences and speculation. More is required before a court can presume to rewrite a statute.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

MARY TATARANOWICZ, et. al, Plaintiffs, v. LOUIS W. SULLIVAN, M.D., Secretary, United States Department of Health and Human Services Defendant	Civil Action No. 90-0935 (Stanley Sporkin) Entered December 21, 1990

MEMORANDUM OPINION

On April 20, 1990, plaintiffs filed this class action for declaratory and permanent injunctive relief, challenging the Secretary of the United States Department of Health and Human Services' (the "Secretary") construction of the transition provisions of the Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. No. 101-234, § 101 (b), 103 Stat. 1979 (1989) (the "Repeal Act"). Plaintiffs contend that the Secretary erroneously construed the transition provisions of the Repeal Act so as to unlawfully deny plaintiffs 100 days of Medicare coverage for skilled nursing facility ("SNF") services furnished on and after January 1, 1990. Plaintiffs have moved for class certification on behalf of all others similarly situated. Plaintiffs have also moved for summary judgment.

Defendant has moved to dismiss the complaint pursuant to Fed. R. Civ. P. 12(b)(1) on the ground that the complaint is outside the Court's subject matter jurisdiction because plaintiffs have failed to exhaust their administrative remedies and because plaintiffs lack standing.[1] On October 26, 1990, this Court held a hearing on plaintiff's motion for summary judgment and defendant's motion to dismiss.

[1]Defendant also argues that the complaint should be dismissed for failure to state a claim upon which relief can be granted. The Court finds that plaintiffs have stated such a claim.

Background:

Title XVIII of the Social Security Act, commonly known as the Medicare Act, 42 U.S.C. §§ 1395 *et seq.*, establishes a federally subsidized health insurance program for the elderly and disabled which is administered by the Secretary. Part A of the Medicare Act, 42 U.S.C. §§ 1395c-1395i-2, provides reimbursements for hospital, post-hospital extended care, and home health care. In 1988, Congress passed the Medicare Catastrophic Coverage Act, Public L. No. 100-360, 102 Stat. 683 (the ''Catastrophic Act''). The Catastrophic Act increased Medicare coverage for post-hospital extended care services in a skilled nursing facility (''SNF'') from the 100 days allowed previously to 150 days during any calendar year; in addition, the new law eliminated the three-day hospital stay previously required to trigger SNF benefits. The Catastrophic Act, which was to be financed by a special federal surtax on senior citizens, was repealed on December 31, 1989, less than one year after it was instituted. The Repeal Act was enacted on December 13, 1989 and was made effective as of midnight on December 31, 1989. The Repeal Act returned to the SNF coverage provisions that were in effect prior to the enactment of the Catastrophic Act. Under the Repeal Act Medicare benefits for SNF services provided on and after January 1, 1990 are limited to 100 days and are available only where the beneficiary is transferred to an SNF within 30 days after being a patient in a hospital for no less than three consecutive days (the ''post-hospital requirement'').

Under the Repeal Act, Congress created certain transition rules to take care of individuals who were relying on benefits they received under the Catastrophic Act for their health care. With regard to extended care services coverage, the transition rule stated:

> [T]he limitation of coverage of extended care services to post-hospital extended care services shall not apply to an individual receiving such services from a skilled nursing facility during a continuous period beginning before (and including) January 1, 1990, until the end of the period of 30 consecutive days in which the individual is not

> provided inpatient hospital services or extended care services . . . .

PUB. L. No. 101-234, §101 (b)(1)(C).

This case involves the interpretation given to this transition provision by the Secretary of the Department of Health and Human Services (the "Secretary") who, on his own, redefined the provision as follows:

> [A] beneficiary whose stay in a SNF . . . continues from 1989 to 1990 is initially exempt from the post-hospital requirement that is reinstated in 1990 . . . . *if all other requirements for Medicare payment for extended care services are met for a continuous period that includes at least 12/31/89 and 1/1/90 . . . . If Medicare payment cannot be made for extended care services furnished on both December 31, 1989 and January 1, 1990, this transition exemption does not apply.*

Skilled Nursing Facility Manual (the "SNF Manual"), HCFA-Pub. 12, § IM 501 (Rev. IM-89-2, Jan. 1990) at 6 (emphasis added). *See also* Medicare Intermediary Manual ("Intermediary Manual"), HCFA-Pub. 13-3, § IM 3623 (Rev. IM-90-1, Feb. 1190); 55 Fed. Reg. 24159, 24160 (June 14, 1990).

Under the Secretary's construction of the Repeal Act, then, to obtain the additional 100 days of Medicare SNF coverage for services provided on or after January 1, 1990, a beneficiary must not only have received extended care services — services furnished by an SNF, *see* 42 U.S.C. §1395x(h) — on both December 31, 1989 and January 1, 1990, but the beneficiary must also have received Medicare *payment* for those services on those days. This means that an SNF resident who, for example, had exhausted his or her 150 days of coverage on December 30, 1989, and therefore was not covered for the services received over the next 2 days, would not qualify under the transition provision for 100 additional days. The only way that this individual could obtain coverage for SNF services in 1990 would be to return to the hospital for a three-day stay and then be readmitted to an SNF. *See* Intermediary Manual, § IM 3623 (beneficiary who

exhausted the SNF benefit period earlier in 1989, "does not qualify for exemption from the post-hospital requirement on January 1, 1990, because Medicare did not pay for December 31.")

Plaintiffs contest this construction of the transition provision on various substantive and procedural grounds. Primarily, plaintiffs contend that the express and unambiguous language of § 101 (b)(1) provides that SNF residents who received "extended care services" continuously during a period including December 31, 1989 and January 1, 1990, are automatically entitled to a new benefit period of up to 100 days for 1990 without having to satisfy the post-hospital requirement. According to plaintiff, the Repeal Act does not require that the care which the SNF resident received on December 31 and January 1 had been paid for by the resident's Medicare benefits. They take the position that the statute simply requires that the resident received "such services" in order to qualify for 100 days of additional coverage for those services in 1990.

Plaintiffs contend that defendant's transitional policy unlawfully denies plaintiffs and others similarly situated SNF Medicare benefits to which they are entitled under the Repeal Act.

The Repeal Act:

Congress in § 101 (b)(1)(C) of the Repeal Act extended transition benefits to "an individual receiving *such services* from a skilled nursing facility during a continuous period beginning before (and including) January 1, 1990." (Emphasis added). The controversy at issue here involves the definition of the term "such services." Plaintiffs contend that the words should be interpreted according to their plain meaning, that is, SNF extended care services, whereas defendant argues that the term covers only those SNF services which were actually covered by Medicare benefits on December 31, 1989, and January 1, 1990.

This Court holds that defendant's policy of limiting benefits under the Repeal Act only to residents who actually received Medicare payment for services received on December 31, 1989

and January 1, 1990, is at odds with the plain and unambiguous language of the statute and finds no support in its legislative history. The language of § 101 (b)(1)(C) is capable of only one interpretation. The Repeal Act provides that in order to be eligible for 100 days of SNF transition coverage in 1990, an SNF resident must have done nothing more than receive extended care services from an SNF on December 31, 1989 and January 1, 1990. There is no requirement that the SNF services received actually have been paid for by Medicare.

Congress must be taken to have intended what it plainly expressed. This is a basic principle of statutory construction. The court's role is simply to enforce a statute according to its plain terms *United States v. Ron Pair Enterprises, Inc.*, 190 S.Ct. 1026, 1030 (1989) [sic]; *American Tobacco Co. v. Patterson*, 102 S.Ct. 1534, 1537 (1981). In this case there is no support for the Secretary's expanded interpretation of the statute. Neither the Joint Explanatory Statement of the Conference Report nor the pre-conference bills contain any language suggesting that Congress desires to limit transition coverage to patients who were actually covered, i.e., actually reimbursed for SNF services, on the days in question.

In support of its position, defendant cites a number of statements made by individual Congressmen. These provide defendant with little if any comfort. In introducing the first version of his bill, Representative Donnelly stated:

> [t]he bill repeals all benefits, generally, effective on January 1, 1990. However, to the extent that a beneficiary is receiving benefits under the bill on that date, the beneficiary is generally held harmless. Thus, if a beneficiary was hospitalized in 1989, the days of hospitalization in that year are not treated as a spell of illness. In addition, a beneficiary who is hospitalized on January 1, 1990 will not have to pay a second deductible during that spell of illness.

135 Cong. Rec. H5125. The reference in this statement is not to § 101 (b)(1)(C) but rather to provisions regarding the determination

of a "spell of illness" and the inpatient hospital deductible. Defendant's unexplained use of the statement is therefore incomprehensible. Actually, the plain meaning of the entire statement, to the effect that a patient who was hospitalized on January 1, 1990, would qualify for special consideration under the Repeal Act, undermines defendant's theory. The words "was hospitalized" are used, and there is no mention of a requirement that hospitalization must have been paid for by Medicare.[2]

Defendant also makes reference to a comment made by Senator Roth that the transitional rules "help accomplish repeal in a manner that is not disruptive to individuals currently receiving benefits." 135 Cong. Rec. S12882. This statement gives defendant little help. Plaintiffs have given a reasonable interpretation to this comment, namely, that the word "currently" should be read normally to mean during 1989, as Senator Roth made this statement on October 6, 1989. "Currently" certainly cannot be read to mean "on and before January 1, 1990." The logical interpretation is that eligibility for transition benefits requires that recipients must have been receiving Medicare benefits at some point during 1989. The plain reading of Senator Roth's statement is consistent with this, rather than with the more strained interpretation suggested by defendant.

Senator Coats' statement, although offered by defendant, seems to be more helpful to plaintiffs' position. Senator Coats, a co-sponsor of the Repeal Act, explained that its intent was "to insure that no Medicare beneficiary [would] be forced out of a hospital room or nursing home bed due to repeal." 135 Cong. Rec. S12887. This statement is entirely consistent with plaintiffs' interpretation of the Repeal Act, namely, that anyone who was in an SNF at the end

[2]Defendant argues that the second reference to "the bill" is the Catastrophic Act rather than the Repeal Act, and that therefore Representative Donnelly's statement encompasses only patients "receiving benefits" on the given dates. However, the Catastrophic Act was already an Act at the time of Representative Donnelly's statement, as it was already part of the Medicare statute, and thus, it would not have been referred to as a "bill." On the other hand, the Repeal Act was only a bill at this time, and thus the statement must be understood to mean that under the Repeal Act, patients need not actually have been "covered" on January 1, 1990.

of 1989 would receive 100 additional days in 1990, automatically, and would not "be forced out" of that facility.

Defendant next argues that this Court should look to the letter written by Representative Donnelly to HCFA on December 21, 1989, some 8 days after the Repeal Act was signed into law. In his letter, the Congressman stated that the "intent of this provision was to limit the benefit of the exemption to individuals for whom Medicare was making payment at the end of 1989," Letter of Representative Donnelly at 1 (Defendant's Motion to Dismiss, Exhibit G). This letter was in response to a telephone call from HCFA after the Secretary had determined that his narrow interpretation of the statute, would save the Treasury some $460 million dollars. This Court does not find Congressman Donnelly's statement compelling because "statements by individual legislators should not be given controlling effect," especially where they are inconsistent with statutory language and other legislative history. *Brock v. Pierce County,* 106 S.Ct. 1834, 1840-41 (1986) (citations omitted). This letter was written after passage of the Repeal Act, and while it may reflect Representative Donnelly's later thoughts about the Act, it neither corresponds with anything discussed during the passage of the Act nor parallels any of the language actually used in the statute.

It is clear, based on the statutory language and the legislative history, that the Repeal Act was intended to extend 100 days of transitional extended care benefits in 1990 to patients who were in an SNF under the provisions of the Catastrophic Act, regardless of whether those patients actually received Medicare benefits on December 31, 1989 and January 1, 1990.

The Secretary's interpretation is not only inconsistent with the language of the statute but also suffers from being illogical. The Secretary admittedly would extend transition benefits to all SNF patients who were receiving benefits on January 1, 1990. However, without the transition period provisions, the Repeal Act would automatically end coverage at midnight on December 31, 1989, for every SNF patient who had not satisfied the post-hospital requirement prior to being admitted. While these patients might continue

to receive services after this date, they would no longer be entitled to receive Medicare payment. The transition provisions were intended to remedy this situation. However, under the Secretary's position, namely, that only patients *covered* on *January 1, 1990* are entitled to transition benefits, not one person cut off by the Repeal Act would be helped. Rather, only those patients who were not affected by the Repeal Act because they had satisfied the post-hospital requirement, and who therefore *were* covered on January 1, 1990, would qualify for transition benefits. This is clearly not what Congress intended, and the Secretary's policy literally makes no sense.

Because the Secretary's interpretation of the Repeal Act's transition provisions is inconsistent with what this Court deems to be Congress' express statutory mandate, this Court need not defer to the agency. *I.N.S. v. Cardoza-Fonseca*, 107 S.Ct. 1207 (1987); *N.L.R.B. Union v. FLRA*, 834 F.2d 191, 198 (D.C. Cir. 1987); *Waterman S.S. Corp. v. Burnley*, 691 F. Supp. 1524, 1533 (D.D.C. 1988). The statutory provision at issue in this case is unambiguous and allows for only one reasonable construction. Even if there were some ambiguity, a court need not defer to an agency's views on a "pure question of statutory interpretation." *Union of Concerned Scientists v. United States Nuclear Regulatory Commission*, 824 F.2d 108, 113 (D.C. Cir. 1987).

Remedial statutes should be broadly construed so as to effectuate their remedial purposes and serve the interests of the individuals they were designed to protect. *Rodriguez v. Compass Shipping Co., Ltd.*, 101 S.Ct. 1945 (1981); *Bell v. Brown*, 577 F.2d 849 (D.C. Cir. 1977). The Medicare laws should be construed so as "not to disentitle old, chronically ill and basically helpless, bewildered, confused people." *Gartman v. Department of Health and Human Services*, 633 F. Supp. 671, 679 (E.D.N.Y. 1986). There is therefore no justification, given the clear language of the statute and the legislative history, to defer to the Secretary's overly restrictive interpretation of § 101 (b)(1)(C). Accordingly, this Court finds as a matter of law that the Secretary's interpretation is invalid.

Class Certification:

Plaintiffs have moved for certification of a class consisting of all individuals who have been or will be denied Medicare SNF coverage pursuant to the Secretary's policy of requiring that patients who received extended care services on December 31, 1989, and January 1, 1990, must also have actually received Medicare coverage on those days in order to be eligible for 100 days of coverage in 1990 without having to satisfy the post-hospital requirement. This class consists of thousands of individuals all over the United States who were receiving extended care services on December 31, 1989, and January 1, 1990, but have been or will be denied coverage for skilled nursing facility benefits in 1990 under the Repeal Act due to the Secretary's flawed interpretation of that statute.

All of these individuals are commonly affected by the Secretary's interpretation of the Repeal Act. Whether the Secretary has correctly construed that Act so as to deny these individuals SNF benefits in 1990 is a question of law common to all these individuals.

The named plaintiffs in this action are elderly individuals who were receiving extended care services at an SNF for a continuous period including December 31, 1989, and January 1, 1990. They received 150 days of SNF benefits under the Catastrophic Act in 1989.[3] Plaintiffs have either had their claims for 1990 Repeal Act coverage denied by an insurance intermediary, have had their benefits for 1990 recouped, or have submitted initial determination/reconsideration requests. *See* Plaintiff's Memorandum Regarding Status of Plaintiff's Claims.

Under plaintiffs' interpretation of the Repeal Act, they should automatically qualify for 100 days of SNF benefits in 1990. The Secretary, however, has denied plaintiffs that coverage unless the care they received on the days of December 31 and January 1 was actually covered by Medicare.

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[3]Plaintiffs received these benefits without having to satisfy the post-hospital requirement.

The plaintiffs have clearly satisfied the three requirements for class certification pursuant to Fed. R. Civ. P. 23 (b)(2). First, the members of the class are so numerous that joinder would be impracticable. Second, the questions of law and fact are common to all members of the class and the claims of the representative parties are typical of the entire class. All members of the class and all the named plaintiffs have the same interest — obtaining a reversal of the Secretary's policy in order to obtain 100 days of SNF benefits in 1990 under the Repeal Act. There is no requirement that a factual record be developed, as the issue raised is discrete and narrow and is thus particularly well-suited for determination as a class action. Moreover, the representative parties will fairly and adequately protect the interest of the class as a whole. The Center for Medicare Advocacy has wide experience in Medicare-related litigation and has demonstrated admirable commitment to furthering the interests of the elderly.

Defendant's objection to class certification centers on his view that each plaintiff requires an individualized administrative review before he or she can obtain a reversal of a denial of benefits. However, defendants miss the focus of plaintiffs' claims. Plaintiffs are attacking the legitimacy of the Secretary's interpretation of a Congressional enactment. Thus, plaintiffs satisfy the third requirement for class certification as well: the Secretary has acted on grounds generally applicable to the class, thereby making appropriate relief with respect to the class as a whole:

> Plaintiff[s] . . . [do] not request an adjudication of individual class members' entitlement to benefits. Rather [they] seek[ ] only a determination of the validilty of certain administrative regulations and policies which themselves determine eligibility when applied to specilfic cases.

Pratt v. Heckler, 629 F. Supp. 1496, 1503, *reconsideration denied sub nom. Pratt v. Bowne*, 642 F. Supp. 883, 885-87 (D.D.C. 1986).

Defendant argues that these individuals cannot comprise a class because their claims are premature and inchoate, as the class is not restricted to those individuals who have actually been denied benefits

after presenting a claim. To begin with, this Court takes note of plaintiffs' argument that many putative class members were notified by their SNF that they were ineligible for transitional benefits without being informed of their right to appeal this decision or with instructions drafted by the Secretary which implied that review was available only of the beneficiary's claim, and not of the Secretary's interpretation of the Repeal Act. Plaintiffs' Memorandum of Points and Authorities in Opposition to Defendant's Motion to Dismiss at 5-12. Therefore, a failure by a putative class member to present a claim after being informed by the SNF that benefits were not available given the Secretary's transition policy is attributable to misinformation on the part of the Secretary, rather than a desire to avoid the administrative process.

The class appropriately includes those individuals who have been denied or who *will* be denied benefits because of the Secretary's interpretation of the Repeal Act. Hence, all members of the class either have or will meet the jurisdictional "presentment" requirements *before* becoming a member of the class. This is not unlike the class certified by the district court in *Bowen v. City of New York,* 106 S.Ct. 2022, 2027 n. 6 (1986), where the class included all individuals whose "applications for benefits have been denied or *whose benefits have been or will be terminated on the basis of defendants' determination* that such people are capable of substantial gainful activity." (Emphasis added).

This case presents compelling reasons for class certification. The plaintiffs are elderly and sick Medicare patients. They are dependent on the receipt of Medicare benefits for their care; whether or not they receive 100 days of coverage in 1990 would influence their economic ability to arrange for future health care. Moreover, because of their age and infirmity, plaintiffs are particularly vulnerable to the time process and errors of the administrative process. One of the original named plaintiffs in this case has already passed away without having her Medicare benefits claim adjudicated.

For the foregoing reasons, this Court certifies a nationwide class consisting of all persons who have been or will be denied SNF

Medicare benefits due to the Secretary's construction of § 101(b)(1)(C) of the Repeal Act.

Exhaustion:

Plaintiffs argue that this Court has jurisdiction pursuant to 42 U.S.C. § 405 (g) as incorporated by 42 U.S.C. § 1395ff. Section 405 (g) provides:

> Any individual, after any final decision of the Secretary made after a hearing to which he was a party . . . may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Secretary may allow.

Defendant's primary contention is that this Court lacks jurisdiction to hear plaintiffs' action because the plaintiffs have failed to exhaust their administrative remedies. According to defendants, ''[t]his case involves a simple failure to exhaust administrative remedies.'' Defendant's Reply to Plaintiffs' Opposition to Defendant's Motion to Dismiss at 1. Defendant argues that the Court cannot review the Secretary's instructions in the SNF manual. According to defendant, this Court can only review each individual plaintiff's eligibility if plaintiff has been denied benefits after compliance with the defendant's 4-step administrative review process.

The first step in this process consists of presenting a formal claim to a fiscal intermediary within one year of the date health care services are provided.[4] The fiscal intermediary, with whom the Secretary contracts, makes the initial determination of the claim's merit on behalf of the Secretary. If the claim is denied, the claimant has a right to reconsideration by the Health Care Financing Administration (''HCFA''), which reviews the intermediary's determination, the administrative record, and any additional information provided by the claimant. If the claim is still denied, the claimant has a right to an administrative appeal before an Administrative Law

[4]The fiscal intermediary is usually an insurance company.

Judge (''ALJ'').[5] If the ALJ denies the claim, review may be obtained from HHS' Appeals Council.

Defendant argues that the Secretary is not deemed to have rendered a ''final decision'' until all four steps in the administrative process have been completed. Defendant contends that the Supreme Court in *Heckler v. Ringer,* 104 S.Ct. 2013 (1984), provided that a court may not review a claim arising under the Medicare Act unless all four steps in the administrative process have been pursued. However, *Ringer* does not stand for the proposition that a court may *never* intervene before the administrative process has been exhausted. The *Ringer* Court noted that while plaintiff *must* meet the requirement of initially presenting a claim before federal court jurisdiction attaches, the requirement that the claimant fully pursue the prescribed administrative remedy is ''waivable.'' *Ringer,* 104 S.Ct. at 2023.[6]

Among the elements to be considered by the court in its application of the exhaustion requirement is whether the plaintiffs' claim is wholly ''collateral'' to their claim for benefits and whether they have a colorable claim that an erroneous denial in the early stages of the administrative process would injure them in a manner which could not be remedied by later payment of benefits. *Id.* In addition, where further exhaustion would be futile, the Supreme Court noted that ''deference to the Secretary's conclusion as to the utility of pursuing the claim through administrative channels is not always appropriate.'' *Id.*

For example, the Supreme Court in *Bowen* held that the district court properly waived the exhaustion requirement to permit plaintiffs to challenge an internal policy of the Secretary that denied disability benefits to any claimant who did not meet the Secretary's list of

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[5]This applies to claims for $100 or more.

[6]Moreover, defendant's reliance on *Ringer* is somewhat misplaced. In *Ringer,* the only effect of the Secretary's ruling on plaintiffs was to require them to pursue the administrative process. Plaintiffs in *Ringer* were assured benefits at the end of the administrative proceeding, which is not the case with the plaintiffs before this Court. Moreover, the Supreme Court noted that the determination of benefit eligibility was completely within the Secretary's discretion and competence, whereas the question of a provision's constitutionality is not. *Bowen,* 104 S.Ct. at 2023 n.11.

specified impairments. Plaintiffs there argued that the presumption led to routine denials of eligible claimants, and the policy was therefore arbitrary and capricious in violation of the Social Security Act and applicable regulations.

The *Bowen* Court, in considering whether it was permissible to hear the claims of these plaintiffs notwithstanding the Secretary's exhaustion procedure, quoted the landmark case of *Mathews v. Elridge*, 96 S.Ct. 893, 900 (1976): "cases may arise where a claimant's interest in having a particular issue resolved promptly is so great that deference to the agency's judgment is inappropriate." *Bowen*, 106 S.Ct. at 2031.

Applying the *Ringer* analysis, the Supreme Court held that the plaintiffs in *Bowen* were entitled to immediate relief without exhausting their administrative remedies on the basis that, first, their claims were collateral to the claims for benefits because "[t]he class members neither sought nor were awarded benefits in the District Court, but rather challenged the Secretary's failure to follow the applicable regulations." *Id.* at 2032. Second, the Court held that "the claimants . . . would be irreparably injured were the exhaustion requirement . . . enforced against them." *Id.* The Court considered the severe medical conditions of the plaintiffs and noted that a court "should be especially sensitive to this kind of harm where the Government seeks to require claimants to exhaust administrative remedies merely to enable them to receive [what] they should have been afforded in the first place." *Id.*

In sum, the Bowen Court held that, notwithstanding its holding in *Ringer*, where a claimant alleges more than deviation from applicable regulations and instead asserts a "systemwide . . . policy that [is] inconsistent in critically important ways with established regulations" and which does not depend on the particular facts of the claimant's case, the exhaustion requirement may be excused. *Bowen*, at 2032-33.

The case currently before this Court is squarely governed by the holding in *Bowen*. Plaintiffs in this case do not seek an award of benefits to indiviudal claimants but rather a court determination

that the Secretary's policy violates the Repeal Act. The interpretative issue raised by plaintiffs is clearly collateral to their individual claims for benefits.

Plaintiffs in this case are all sick and elderly persons. It would be unreasonable to force each of them to pursue an administrative process with respect to which they were absolutely assured a denial of their claim based upon an impermissible interpretation. Because the intermediary insurance companies work on contract with the Secretary, they are required to follow his interpretations. This means that each and every claim for 1990 SNF transition benefits presented to an intermediary by plaintiffs will be summarily denied. Moreover, these plaintiffs are often stymied even earlier in the process, because the SNF is put on notice that the intermediary will deny the claim and therefore will not file a claim on behalf of the patient until the patient submits a "demand bill," thereby lengthening the process further.

Defendant contends that because only the intermediary is governed by the Secretary's interpretations, there is no basis for an assertion that exhaustion would be futile as it is conceivable that a claimant would be granted benefits, notwithstanding the Secretary's policy, further along in the administrative process. However, it is clear that the plaintiffs will face certain denial at the administrative stage as well as at the intermediary stage, because HCFA follows the Secretary's interpretation. Indeed, it is HCFA that is responsible for crafting the interpretation in the first place.

Whether or not ALJ's and the Appeals Council have certain independence in rendering decisions, they must give great deference to the Secretary's interpretation as it constitutes the applicable law to be enforced. Even in the unlikely event of a reversal by an ALJ or the Appeals Council, there would be no precedential effect outside of the specific claimant's case, and intermediaries would still be bound to treat all other claimants according to the Secretary's existing policy. To force elderly and sick patients to proceed through an elaborate administrative process where an improper interpretation is being applied to deny them their benefits is an indignity that no

individual should suffer. This is certinaly not what is intended by the policy underlying the exhaustion requirement.

It is simply not meaningful to point to the chance that the plaintiffs might obtain a reversal later in the administrative process. Denial of benefits to these elderly plaintiffs will almost certainly cause irreparable harm which cannot be remedied by a later reversal. These plaintiffs are struggling to obtain the funds necessary to arrange for their SNF care. Denial of Medicare benefits can result in indigence, loss of crucial health care, and emotional distress. Moreover, the legal costs involved for each of the plaintiffs to exhaust their administrative remedies and then to pursue individually court contests could be astronomical.[7] As the court in *Fox v. Bowen*, 656 F. Supp. 1236, 1240-1241 (D. Conn. 1986) explained concerning coverage denials to SNF patients in their mid-80's needing daily skilled physical therapy treatments:

> Patients who are denied Medicare coverage are responsible for paying for their own physical therapy through insurance, personal savings or contributions from family members. . . . In such circumstances, many patients forgo medically necessary physical therapy because they or their families believe that they cannot afford to pay for such therapy themselves. . . .
>
> A patient's recovery may be jeopardized. . . . In some cases, . . . recovery is also inhibited by the emotional distress that may result from a denial of Medicare coverage.

The record before this Court dramatically illustrates these cogent points. Plaintiff Mary Kirwin was moved from a Medicare-certified to a non-certified bed in the nursing home when SNF benefits were denied.[8] Elouise Munoz, another member of the plaintiff class, was denied SNF benefits under the Secretary's interpretation.

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[7]Furthermore, if plaintiffs ultimately prevailed, these legal costs would most likely be borne by the government.

[8]Plaintiff's Memorandum Regarding Status of Plaintiffs' Claims at 5.

Because of this, her right to supplemental insurance was not triggered, and her 1990 bill remained unpaid. The SNF would not readmit her, and she was forced to transfer to a different nursing home, in a county far from the home of her son who was looking after her.[9]

The administrative process is rife with delays. According to information compiled from the Social Security Administration Office of Hearings and Appeals and the Center for Medicare Advocacy, the four-step administrative process would involve an average total of 632 days. *Id.* at 3. While the delay involved in the administrative process is not enough to excuse exhausting that process, in the case of the ill and elderly, mechanical application of that process causes intolerable hardship. Any relief afforded by this Court would not be "[in]consistent with the policies underlying exhaustion" because by simply ordering that "the claims be reopened at the administrative level, this District Court [would show] proper respect for the administraive process . . . . [doing] no more than the agency would have been called upon to do had it, instead of the District Court, been alerted to the charge than an undisclosed procedure was illegal and had improperly resolved innumerable claims." *Bowen,* 106 S.Ct. at 2033.

Plaintiffs are not using this lawsuit to bypass the administrative process but rather to make that process meaningful. What plaintiffs seek in this action is collateral to their claims for benefits, and requiring exhaustion of the administrative process would be futile and would lead to irreparable harm. Accordingly, this Court finds that the class members have standing to bring this suit and that it has jurisdiction to adjudicate their claims.

Conclusion:

Defendant's motion to dismiss will be denied because this Court finds that it has jurisdiction to adjudicate plaintiffs' claims. Furthermore, because this case presents compelling reasons for class

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[9]Plaintiff's Memorandum of Points and Authorities in Opposition to Defendant's Motion to Dismiss at 16.

certification, this Court will grant plaintiffs' motion to certify a nationwide class. Lastly, this Court will grant summary judgment for plaintiff class. The issue before this Court is solely a question of law involving statutory construction; there is no need for further discovery or the establishment of a factual record, as explained above in the certification of the class of plaintiffs. Accordingly, this Court finds that the plaintiffs, as a class, are entitled to summary judgment as a matter of law.

DATE: 12/21/90

/s/ Stanley Sporkin
Stanley Sporkin
United States District Court

FILED
DEC. 21, 1990
CLERK, U.S. DISTRICT COURT
DISTRICT OF COLUMBIA

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

MARY TATARANOWICZ, et. al, Plaintiffs,	)	
v.	)	Civil Action No. 90-0935 (Stanley Sporkin)
LOUIS W. SULLIVAN, M.D., Secretary, United States Department of Health and Human Services Defendant	)	Entered December 21, 1990

ORDER

Having considered plaintiffs' motion for class certification, defendant's motion to dismiss, plaintiff's motion for summary judgment, all opposition thereto, oral argument, and the entire record in this case, it is hereby

ORDERED, that plaintiff's motion for class certification is GRANTED; and it is further

ORDERED, that defendant's motion to dismiss is DENIED; and it is further

ORDERED, that plaintiff's motion for summary judgment is GRANTED; and it is hereby

DECLARED, that the Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. No. 101-234 § 101(b), requires defendant Secretary to grant Medicare skilled nursing facility benefits in 1990 to all individuals who would have been eligible for such benefits under the Medicare Catastrophic Act of 1989, Pub. L. No. 100-360 [sic], and who were receiving extended care services in a Medicare-certified skilled nursing facility for a continuous period including December 31, 1989 and January 1, 1990, regardless of whether such individuals first entered the facility or began their current spells of illness within thirty days of a three-day hospitalization or were receiving Medicare

coverage for those services during that period, and that defendant's contrary policy is not in accordance with the law; and it is further

ORDERED, that defendant Secretary and his agents are permanently enjoined from enforcing defendant's policy of requiring that individuals have actually received Medicare coverage for services received on December 31, 1989 and January 1, 1990 in order to qualify for transition benefits under the Repeal Act; and it is further

ORDERED, that defendant Secretary must apply the correct interpretation of the transition provisions of the Repeal Act to all eligible beneficiaries including these plaintiffs and all others similarly situated.

DATE: 12/21/90

/s/ Stanley Sporkin
Stanley Sporkin
United States District Judge

FILED
DEC. 21, 1990
CLERK, U.S. DISTRICT COURT
DISTRICT OF COLUMBIA

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

MARY TATARANOWICZ, et. al, Plaintiffs, v. LOUIS W. SULLIVAN, M.D., Secretary, United States Department of Health and Human Services Defendant	Civil Action No. 90-935 (Stanley Sporkin) Entered February 28, 1991

MEMORANDUM OPINION AND ORDER

On December 21, 1990, this Court declared invalid defendant's interpretation of the transition provisions of the Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. No. 101-234, 103 Stat. 1979. The government has moved for a stay pending appeal, asserting that the government will be irreparably injured because an estimated $461 million in administrative costs and benefits will be disbursed under this Court's Order if a stay is not granted.

It is within this Court's discretion whether to issue a stay. *See* Fed. R. Civ. P. 62(c). The factors the Court must consider include whether the party seeking the stay has shown a likelihood of succeeding on the merits of the appeal; whether that party will be irreparably harmed absent a stay; whether issuance of the stay will injure the other parties in the action; and where the public interest lies. *Hilton v. Braunskill*, 481 U.S. 770, 776 (1987). I find that the governmet has not satisfied its burden, under this test, for issuance of the stay it seeks.

First, there is no showing that the government is likely to succeed on the merits of the jurisdictional and statutory issues subject to review. This Court's Opinion exhaustively covered all the points that defendant raises in its motion, and defendant has not succeeded in persuading this Court that its arguments are of any greater merit at this point.

Second, the government will not be irreparably harmed. Any Medicare benefits disbursed can be recouped in the event of a reversal on appeal. *See* 42 U.S.C. § 1395gg(a), (b); 42 C.F.R. §§ 405.350-354. There are specific procedures in place for the government to utilize in this regard. The government would incur administrative costs; however, these alone would not amount to irreparable injury requiring a stay.

Third, if a stay is granted, plaintiffs, who are sick and elderly, will be irrreparably injured if they do not receive the benefits which are due them. This Court's original Opinion made clear that plaintiffs are in a position where their health and welfare has in many cases already been negatively affected by the government's wrongful withholding of benefits. For many of these plaintiffs, it may be too late to remedy the situation at this date, and it will certainly be too late if payment of their benefits is stayed pending appeal, even if this Court's Order is ultimately upheld.

Lastly, the public interest requires that the language of the Medicare statute be enforced in accordance with its plain meaning, which is to benefit the sick and elderly. In general, remedial statutes are to be broadly construed so as to serve the interest of those the laws were designed to protect. *See, e.g., Rodriguez v. Compass Shipping Co., Ltd.*, 451 U.S. 596 (1981). The public interest will be best served if the Medicare statute is read so as not to disentitle those it was designed to help.

As the government has not met its burden in seeking a stay of this Court's Order, it is hereby

ORDERED, that defendant's motion to stay is DENIED.

DATE: 2/28/91

/s/ Stanley Sporkin
Stanley Sporkin
United States District Court

FILED
FEB. 28, 1991
CLERK, U.S. DISTRICT COURT
DISTRICT OF COLUMBIA

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 91-5052 **September Term, 1990**
C.A. No. 90-00935

Mary Tataranowicz, *et al.* Entered May 22, 1991

v.

Louis W. Sullivan, M.D., in his official capacity as Secretary, Dept. of HHS,

Appellant

ORDER

Upon consideration of the court's order issued this date expediting this case, it is

ORDERED that the following briefing schedule shall apply:

Brief of Appellant	6/26/91
Brief of Appellees	7/22/91
Reply Brief of Appellant	8/01/91
Deferred Appendix	8/08/91
Final Briefs	8/15/91

It is

FURTHER ORDERED that oral argument is set for September 13, 1991, at 9:30 a.m. before Circuit Judges Buckley, Williams and Thomas.

Because this case has been expedited and the briefing schedule is keyed to the date of argument, the court will grant requests for extension of time limits for briefs or transcripts only for extraordinarily compelling reasons. The parties are directed to hand-file and hand-serve their briefs by close of business on the date due. All briefs and appendices must contain the date that the case is scheduled for oral

argument at the top of the cover. *See* D.C. Cir. Rule 11(a)(1)(C)(6).

A further order of the court will be issued regarding allocation of time for argument. The attached form 72 should be complete and returned to the Clerk's office by September 6, 1991.

FOR THE COURT:
Constance L. Dupré, Clerk

By: /s/ Caryn M. Lewis-Bugg
Caryn M. Lewis-Bugg
Deputy Clerk

United States Court of Appeals
for the District of Columbia Circuit

FILED MAY 22, 1991
CONSTANCE L. DUPRÉ
CLERK

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 91-5052

September Term, 1990
C.A. No. 90-00935

Mary Tataranowicz, *et al.*
v.

Louis W. Sullivan, M.D., in his official capacity as Secretary, Dept. of HHS,

Appellant

Entered May 22, 1991

BEFORE: Wald,* Silberman and Williams, Circuit Judges

ORDER

Upon consideration of the motion to expedite briefing schedule and oral argument and the response thereto; and the motion for stay pending appeal and to expedite briefing schedule and oral argument, the response thereto, and the reply, it is

ORDERED that the motion for stay be granted. Appellant has demonstrated a sufficient likelihood of success to warrant granting such relief. *See Washington Metropolitan Area Transit Comm'n v. Holiday Tours, Inc.*, 559 F.2d 841, 843 (D.C. Cir. 1977); *Virginia Petroleum Jobbers Ass'n v. FPC*, 259 F.2d 921 (D.C. Cir. 1958). It is

FURTHER ORDERED that the motion to expedite be granted. *See D.C. Cir. Handbook of Practice and Internal Procedures* 40 (1987). The parties will be notified by separate order of the briefing schedule and argument date.

Per Curiam

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*Judge Wald would deny the motion for stay.

United States Court of Appeals
For the District of Columbia Circuit

FILED MAY 22, 1991
CONSTANCE L. DUPRE
CLERK

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 91-5052 **September Term, 1991**
CV 90-00935

Mary Tataranowicz, et al. Entered June 1, 1992

v.

Louis W. Sullivan, M.D., in his official capacity as Secretary, Dept. of HHS,

Appellant

BEFORE: Buckley, Williams and Lourie*, Circuit Judges

ORDER

Upon consideration of appellees' petition for rehearing, filed April 27, 1992, it is

ORDERED, by the Court, that the petition is denied.

Per Curiam
FOR THE COURT:
CONSTANCE L. DUPRÉ, CLERK

BY: /s/ Robert A. Bonner
Robert A. Bonner
Deputy Clerk

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*of the United States Court of Appeals for the Federal Circuit, sitting by designation pursuant to 28 U.S.C. § 291(a).

United States Court of Appeals
For the District of Columbia Circuit
FILED JUN. 01, 1992
CONSTANCE L. DUPRÉ
CLERK

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 91-5052 **September Term, 1991**
CV 90-00935

Mary Tataranowicz, et al. Entered June 1, 1992

v.

Louis W. Sullivan, M.D., in his official capacity as Secretary, Dept. of HHS,

Appellant

BEFORE: Mikva, Chief Judge; Wald, Edwards, Ruth B. Ginsburg, Silberman, Buckley, Williams, D.H. Ginsburg, Sentelle, Henderson, Randolph, and Lourie*, Circuit Judges

ORDER

Appellees' Suggestion For Rehearing *En Banc* has been circulated to the full Court. No member of the Court requested the taking of a vote thereon. Upon consideration of the foregoing it is

ORDERED, by the Court *en banc*, that the suggestion is denied.

Per Curiam
FOR THE COURT:
CONSTANCE L. DUPRÉ, CLERK

BY: /s/ Robert A. Bonner
Robert A. Bonner
Deputy Clerk

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*of the United States Court of Appeals for the Federal Circuit, sitting by designation pursuant to 28 U.S.C. § 291(a).

United States Court of Appeals
For the District of Columbia Circuit
FILED JUN. 01, 1992
CONSTANCE L. DUPRE
CLERK

PUBLIC LAW 101-234 [H.R. 3607]; December 13, 1989

MEDICARE CATASTROPHIC COVERAGE REPEAL ACT OF 1989

For Legislative History of Act, see p. 1452.

An Act to repeal medicare provisions in the Medicare Catastrophic Coverage Act of 1988.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled.

Medicare Catastrophic Coverage Repeal Act of 1989. 42 USC 1305 note.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Catastrophic Coverage Repeal Act of 1989"

TITLE I — PROVISIONS RELATING TO PART A OF MEDICARE PROGRAM AND SUPPLEMENTAL MEDICARE PREMIUM

SEC. 101. REPEAL OF EXPANSION OF MEDICARE PART A BENEFITS.

42 USC 1395e note.

(a) IN GENERAL—

(1) GENERAL RULE.—Except as provided in paragraph (2), sections 101, 102, and 104(d) (other than paragraph (7)) of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) (in this Act referred to as "MCCA") are repealed, and the provisions of law amended or repealed by such sections are restored or revived as if such section had not been enacted.

42 Usc 1395c-1395f, 1395k, 1395x, 1395cc, 1395tt.

(2) EXCEPTION FOR BLOOD DEDUCTION.—The repeal of section 102(1) of MCCA (relating to deductibles and coinsurance under part A) shall not apply, but only insofar as such section amended paragraph (2) of section 1813(a) of the Social Security Act (relating to a deduction for blood).

42 USC 1395e note.

(b) TRANSITION PROVISIONS FOR MEDICARE BENEFICIARIES.—

(1) INPATIENT HOSPITAL SERVICES AND POST-HOSPITAL EXTENDED CARE SERVICES.—In applying sections 1812 and 1813 of the Social Security Act, as restored by subsection (a)(1), with respect to inpatient hospital services and extended care services provided on or after January 1, 1990—

(A) no day before January 1, 1990, shall be counted in determining the beginning (or period) of a spell of illness;

(B) with respect to the limitation on such services provided in a spell of illness, days of such services before January 1, 1990, shall not be counted, except that days of inpatient hospital services before January 1, 1989, which were applied with respect to an individual after receiving 90 days of services in a spell of illness (commonly known as "lifetime reserve days") shall be counted;

(C) the limitation of coverage of extended care services to post-hospital extended care services shall not apply to an individual receiving such services from a skilled nursing facility during a continuous period beginning before (and including) January 1, 1990, until the end of the period of 30 consecutive days in which the individual is not provided inpatient hospital services or extended care services; and

(D) the inpatient hospital deductible under section 1813(a)(1) of such Act shall not apply—

(i) in the case of an individual who is receiving inpatient hospital services during a continuous period beginning before (and including) January 1, 1990, with respect to the spell of illness beginning on such date, if such a deductible was imposed on the individual for a period of hospitalization during 1989;

(ii) for a spell of illness beginning during January 1990, if such a deductible was imposed on the individual for a period of hospitalization that began in December 1989; and

(iii) in the case of a spell of illness of an individual that began before January 1, 1990.

(2) HOSPICE CARE.—The restoration of section 1812(a)(4) of the Social Security Act, effected by subsection (a)(1), shall not apply to hospice care provided during the subsequent period (described in such section as in effect on December 31, 1989) with respect to which an election has been made before January 1, 1990.

42 USC 1395e note.

(3) TERMINATION OF HOLD HARMLESS PROVISIONS.—Section 104(b) of MCCA is amended by striking "or 1990" each place it appears.

(c) TERMINATION OF TRANSITIONAL ADJUSTMENTS IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES.—

(1) PPS HOSPITALS.—Section 104(c)(1) of MCCA is amended by inserting "and before January 1, 1990," after "October 1, 1988,".

42 USC 1395ww note.

(2) PPS-EXEMPT HOSPITALS.—

(A) IN GENERAL.—Section 104(c)(2) of MCCA is amended—

(i) by inserting "and before January 1, 1990," after "January 1, 1989,"; and

(ii) by striking the period at the end and inserting the following: ", without regard to whether any of such beneficiaries exhausted medicare inpatient hospital insurance benefits before January 1, 1989.".

42 USC 1395ww note.

(B) TRANSITION.—The Secretary of Health and Human Services shall make an appropriate adjustment to the target amount established under section 1886(b)(3)(A) of the Social Security Act in the case of inpatient hospital services provided to an inpatient whose stay began before January 1, 1990, in order to take into account the target amount that would have applied but for the amendments made by this title.

42 USC 1395c note.

(d) EFFECTIVE DATE.—The provisions of this section shall take effect January 1, 1990, except that the amendments made by subsection (c) shall be effective as if included in the enactment of MCCA.

* * * * *

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

MARY TATARANOWICZ, *et. al*, Plaintiffs,	)	
v.	)	Civil Action No. 90-0935 (SS)
LOUIS W. SULLIVAN, M.D., Secretary, United States Department of Health and Human Services Defendant.	)	

I, Solomon Mussey, declare as follows:

1. I am the Director of the Office of Medicare Cost Estimates, the Office of the Actuary of the Health Care Financing Administration of the Department of Health and Human Services. The information contained in this declaration is based upon my personal knowledge and materials provided to me in the course of my official duties.

2. After the enactment of the Catastrophic Coverage Repeal Act of 1989, Pub. L. No. 101-234, 103 Stat. 1979, I directed my staff to perform estimates of the cost of the transitional benefits provided in §101 (b)(1)(C) of the Repeal Act using two different interpretations of its meaning. These estimates were then used in determining how to draft instructions in the appropriate manuals used by health care providers and fiscal intermediaries in the Medicare claims process.

3. The first estimate assumed that the exemption from the post-hospital requirement applied to all Medicare beneficiaries who were receiving extended care services in skilled nursing facilities (''SNFs'') on December 31, 1989, and who continued to receive such services on January 1, 1990. Under this interpretation, we estimated that the transitional SNF benefits provided in § 101(b) would cost $690 million during 1990.

4. The second estimate assumed that the post hospital exemption applied only to Medicare beneficiaries in the circumstances described above, who were eligible to receive such services subject to reimbursement under the Medicare Catastrophic Coverage Act of 1988 on December 31, 1989. For this second, narrower interpretation we estimated that the SNF transitional benefits would cost $230 million during 1990.

5. These figures represent estimates as of December 1989 and are subject to change.

I swear or affirm under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

6/26/90
DATE

/s/ Solomon Mussey
SOLOMON MUSSEY